

AsiaLymph Study

Screener and Questionnaire

Screener

OMB #: 0925-0654
Expiration date: 10/31/2015

Public reporting for this collection of information is estimated to average 5 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 (0925-0654). Do not return the completed form to this address.

	Name of Study Subject	<input style="width: 95%;" type="text"/>
	Sex	<input type="radio"/> Male <input type="radio"/> Female
	Date of Birth	<input style="width: 30px;" type="text"/> (dd) / <input style="width: 30px;" type="text"/> (mm) / <input style="width: 30px;" type="text"/> (yyyy)

Excluding the current diagnosis, has the subject been previously diagnosed in the past (i.e., more than a year ago) with any lymphoma, including acute lymphoblastic lymphoma, multiple myeloma, chronic lymphocytic leukemia, Hodgkin lymphoma, and non-Hodgkin lymphoma or with any myeloid neoplasms or acute leukemia?	<input type="radio"/> Yes (prior history of lymphoma, myeloid neoplasms or acute leukemia) <input type="radio"/> No (no prior history of lymphoma, myeloid neoplasms or acute leukemia)
--	--

	Current area of residence	Hong Kong Island ▾ Select answer Hong Kong Island Kowloon New Territories Any other area
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Hong Kong

Yes No

Have you lived in this general area for at least 15 years at anytime in your life?
Note: The general area refers to all areas listed in the previous question except 'any other area'

[Provide Extra Comments](#)

	Have you ever been enrolled previously into this study, at either this hospital or at any other participating hospital?	<input type="radio"/> Yes <input type="radio"/> No
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[Provide Extra Comments](#)

Questionnaire

OMB #: 0925-0654
Expiration date: 10/31/2015

Public reporting for this collection of information is estimated to average 70 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 (0925-0654). Do not return the completed form to this address.

A. ETHNIC GROUP AND BIRTH PLACE:	
1A.1	<div style="display: flex; justify-content: space-between;"> What is your Ethnic group? <div style="margin-left: 10px;"> <input type="radio"/> Chinese Han <input type="radio"/> Chinese Minority (Specify) <input style="width: 80px;" type="text"/> <input type="radio"/> Caucasian <input type="radio"/> Other group (Specify) <input style="width: 80px;" type="text"/> </div> </div>
1A.2	<div style="display: flex; justify-content: space-between;"> What is your Father's Ethnic group? <div style="margin-left: 10px;"> <input type="radio"/> Chinese Han <input type="radio"/> Chinese Minority (Specify) <input style="width: 80px;" type="text"/> <input type="radio"/> Caucasian <input type="radio"/> Other group (Specify) <input style="width: 80px;" type="text"/> </div> </div>
1A.3	<div style="display: flex; justify-content: space-between;"> What is your Mother's Ethnic group? <div style="margin-left: 10px;"> <input type="radio"/> Chinese Han <input type="radio"/> Chinese Minority (Specify) <input style="width: 80px;" type="text"/> <input type="radio"/> Caucasian <input type="radio"/> Other group (Specify) <input style="width: 80px;" type="text"/> </div> </div>
1A.4	<div style="display: flex; justify-content: space-between;"> Where were you born? <div style="margin-left: 10px;"> <input type="radio"/> Hong Kong <input type="radio"/> PR China - What province? <input style="width: 80px;" type="text"/> <input type="radio"/> Other country (Specify) <input style="width: 80px;" type="text"/> </div> </div>

[Provide Extra Comments](#)

If No (0) Siblings, Go To 1C.1

B. SIBLINGS

1B.1	How many total siblings do you have? Please include all living or deceased brothers and sisters, but <u>do not count</u> adopted or half-siblings, and <u>do not count</u> yourself.	<input type="text"/>
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[Provide Extra Comments](#)

1B.2	What is the order number that you are within your siblings? If you are the oldest child among siblings, your order number is "1." If you are the second-oldest child, you would be number "2," and so on.	<input type="text"/>
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1B.3	How many brothers do you have (not counting yourself)?	<input type="text"/>
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1B.4	How many sisters do you have (not counting yourself)?	<input type="text"/>
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[Provide Extra Comments](#)

C. EDUCATION AND BODY SIZE

1C.1 What was the highest level of education you have reached?

If 'None' is selected, Go to 1C.3

- None
- Primary school - some
- Primary school - completed
- Middle school - some
- Middle school - completed
- Secondary school - some
- Secondary school - completed
- Technical school - some
- Technical school - completed
- College/University - some
- College/University - completed
- Master's degree
- Advanced degree (above Master's)
- Other level (Specify:)

1C.2 How many years, in total, did you attend school?
 Years

1C.3 What is your current height?
 cm OR ft inches


1C.4 Please recall and estimate your weight at age 20:
 kg or pounds

1C.5 Please recall and estimate your weight at age 40:
 kg or pounds


If <Age 40, Skip to 1C.6

1C.6 What was your weight approximately 1 year ago?
 kg or pounds


1C.7 Which of the following best describes your body type as a child at age 10?



Thin



Medium build



Heavy-set

[Provide Extra Comments](#)

D. OCCUPATIONAL HISTORY

Now I'd like to ask you some questions about the kind of work you have done.

We are interested in every job, at home, or outside the home, part-time or full-time, paid or unpaid, including work on a farm, any self-employment, or work for companies or family businesses (excluding housewife), which you held for a total of 12 months or longer since you first began working.

1D.1 Are you currently employed, not employed, or retired? EMPLOYED
 NOT EMPLOYED
 RETIRED

[Provide Extra Comments](#) << >>

1D.3 Did you ever have any jobs, held for a total of 12 months or longer, either outside the home or at home (?)... Yes
 No
 Don't Know

[Provide Extra Comments](#) << >>

If Yes, Go To INTRO for 1D.4

If No or Don't Know, Go To INTRO for 2A.1

INTRO for 1D.4

If you held more than one job at a company (or at home), or more than one job at the same time, we would like to talk about each job separately. Also, please include any seasonal work and any time while in the military. Let's begin by listing only the employer name, job title, and years worked at each of these jobs.

jobHistory Grid	EMPLOYER-1D.4 What was the name of the employer or workplace where you (first/next) worked for a total of 12 months or longer?	JOB TITLE-1D.5 What was the job title of the (first/next) job you held for 12 months or longer at (EMPLOYER-1D.4)?	START-1D.6 When did you start working as a JOB TITLE-1D.5? How old were you or what year was it?		STOP 1D.7 When did you stop working as a (JOB TITLE-1D.5) at (EMPLOYER-1D.4)? How old were you or what year was it?	
			Age, OR	Year	Age, OR	Year
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						

Do you have any more jobs to add? If yes, please click here!!

Confirm So just to confirm, the most recent job you held ended in [last Age, Year (1D.7) in grid]. Is that correct? Yes
 No

[Provide Extra Comments](#) << >>

Go To 1D.4 and begin completing grid
 When you have obtained 1D.4-1D.7 for all jobs (up to 12 total jobs available for entry on CAPI), GO TO 1D.8 for 1st job. Then ask 1D.8 through 1D.16 for the first job and then repeat for all additional jobs

1st Job Questions

1D.8	When you worked at [EMPLOYER 1D.4] from [YEAR 1D.6] to [YEAR 1D.7] what did they make, or what service did they provide?	<input style="width: 90%;" type="text"/>
1D.9	How many months per year did you usually work on this job?	<input type="text"/> MONTHS PER YEAR
1D.10	On average, how many days per week did you work on this job?	<input type="text"/> DAYS PER WEEK
1D.11	On average, about many hours per day did you work on this job?	<input type="text"/> HOURS PER DAY
1D.12	In this job, on average, about how many hours did you spend outdoors on a normal working day on this job?	<input type="text"/> HOURS PER DAY OUTDOORS
1D.13	What were your main activities or duties as a [JOB TITLE 1D.5] at [EMPLOYER 1D.4]?	<input style="width: 90%;" type="text"/>
1D.14	In this job, did you ever use paints, stains or varnishes or work in an area where they were used?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know
1D.15	In this job, did you ever use solvents, glues, degreasing agents (to clean metal parts), gasoline or other fuels, or work in an area where they were used?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know
1D.16	In this job, did you ever use particle board, plywood, or veneered woods or work in an area where they were used?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know

[Provide Extra Comments](#)

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2nd Job Questions

1D.8	When you worked at [EMPLOYER 1D.4] from [YEAR 1D.6] to [YEAR 1D.7] what did they make, or what service did they provide?	<input style="width: 90%;" type="text"/>
1D.9	How many months per year did you usually work on this job?	<input type="text"/> MONTHS PER YEAR
1D.10	On average, how many days per week did you work on this job?	<input type="text"/> DAYS PER WEEK
1D.11	On average, about many hours per day did you work on this job?	<input type="text"/> HOURS PER DAY
1D.12	In this job, on average, about how many hours did you spend outdoors on a normal working day on this job?	<input type="text"/> HOURS PER DAY OUTDOORS
1D.13	What were your main activities or duties as a [JOB TITLE 1D.5] at [EMPLOYER 1D.4]?	<input style="width: 90%;" type="text"/>
1D.14	In this job, did you ever use paints, stains or varnishes or work in an area where they were used?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know
1D.15	In this job, did you ever use solvents, glues, degreasing agents (to clean metal parts), gasoline or other fuels, or work in an area where they were used?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know
1D.16	In this job, did you ever use particle board, plywood, or veneered woods or work in an area where they were used?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know

[Provide Extra Comments](#)

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3rd Job Questions

1D.8	When you worked at [EMPLOYER 1D.4] from [YEAR 1D.6] to [YEAR 1D.7] what did they make, or what service did they provide?	<input type="text"/>
1D.9	How many months per year did you usually work on this job?	<input type="text"/> MONTHS PER YEAR
1D.10	On average, how many days per week did you work on this job?	<input type="text"/> DAYS PER WEEK
1D.11	On average, about many hours per day did you work on this job?	<input type="text"/> HOURS PER DAY
1D.12	In this job, on average, about how many hours did you spend outdoors on a normal working day on this job?	<input type="text"/> HOURS PER DAY OUTDOORS
1D.13	What were your main activities or duties as a [JOB TITLE 1D.5] at [EMPLOYER 1D.4]?	<input type="text"/>
1D.14	In this job, did you ever use paints, stains or varnishes or work in an area where they were used?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know
1D.15	In this job, did you ever use solvents, glues, degreasing agents (to clean metal parts), gasoline or other fuels, or work in an area where they were used?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know
1D.16	In this job, did you ever use particle board, plywood, or veneered woods or work in an area where they were used?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know

[Provide Extra Comments](#)

<< >>

NOTE: After asking questions 1D.8 through 1D.16 for the last job, Go To 1D.17 INTRO.

INTRO. The last question in this section is about night shift work.

This question pertains to the whole occupational history and not only to the last job.

1D.17	Have you ever worked at night for at least 1 hour between midnight and 5am?	<input type="radio"/> Yes <input type="radio"/> No
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If NO, Go to OccIDEAS transition screen.

[Provide Extra Comments](#)

<< >>

1D.17a	Have you ever worked rotating night shifts (defined as at least three nights/month in addition to days and evenings in that month)?	<input type="radio"/> Yes <input type="radio"/> No
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If NO, Go to OccIDEAS transition screen.

[Provide Extra Comments](#)

<< >>

1D.17b	What is the total number of years you worked in rotating night shifts?	<input type="text"/> YEARS
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[Provide Extra Comments](#)

<< >>

OccIDEAS
Screen

Transition

English

Step 1: We will now review the specialized occupational questions (OccIDEAS) BEFORE you proceed to Next Question! Please click the buttons below.

Start occIDEAS

OR

Review occIDEAS

Step 2: Please press the below button to check if you have completed the OccIDEAS. If it is completed, you will see >> button below to proceed to Next Question. Else, please make sure you have completed OccIDEAS or contact support.

Check if completed

[Provide Extra Comments](#)

<<

I would now like to ask about your personal medical history.

A. ALLERGIES AND MEDICAL HISTORY

If No or Don't Know
Go To 2A3.1

2A.1 Do you have any allergies, excluding drug allergies? Yes No Don't Know

[Provide Extra Comments](#)

<< >>

2A.1a When was your first allergic episode or reaction? AGE, OR YEAR

2A2.1 ~ 2A2.6 Have you ever been allergic to any of the following? If yes, When was your first allergic reaction?

	Yes	No	Don't Know	AGE	OR	YEAR
Any food products? (If yes), Please specify type of foods: <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>		<input type="text"/>
Any insects? (If yes), Please specify type of insects: <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>		<input type="text"/>
Any animals? (If yes), Please specify type of animals: <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>		<input type="text"/>
Dust or dust mites	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>		<input type="text"/>
Mold?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>		<input type="text"/>
Pollen from trees, plants, or grasses? (If yes), Please specify type of pollen: <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>		<input type="text"/>

2A2.7 Have you ever been treated by a physician with 'allergy shots' (that is, immunizations to reduce your sensitivity to a substance to which you are allergic)? Yes No Don't Know

If No or Don't Know, Go To 2A3.1

2A2.8 Have you ever been treated emergently for a severe allergic reaction including epinephrine? Yes No Don't Know

[Provide Extra Comments](#)

<< >>

2A2.8a How many times were you treated with epinephrine?

[Provide Extra Comments](#)

<< >>

2A3.1 ~ 2A3.3 Have you ever been told by doctor that you had any of the following illnesses? By "doctor" we mean a trained physician, hospital or clinic doctor (not including a village doctor).

	Yes	No	Don't Know	AGE, OR	YEAR
Asthma?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>
"Hay fever" (Allergic Rhinitis)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>
Eczema or dermatitis?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>

[Provide Extra Comments](#)

<< >>

2A3.4 ~
2A311.4

Have you ever had any of the following diseases?																																																																													
	a. Was this condition diagnosed by a doctor?			b. When were you first diagnosed?		c. Did you receive treatment for this condition?			d. If yes, what type of treatment?																																																																				
	Yes	No	Don't Know	Age, OR	Year	Yes	No	Don't Know																																																																					
Related to skin																																																																													
Shingles	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/> Age, OR	<input type="text"/> Year	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>																																																																				
Other conditions																																																																													
Tuberculosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/> Age, OR	<input type="text"/> Year	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>																																																																				
Childhood diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/> Age, OR	<input type="text"/> Year	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>																																																																				
Adult diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/> Age, OR	<input type="text"/> Year	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>																																																																				
Rheumatoid arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/> Age, OR	<input type="text"/> Year	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>																																																																				
Systemic lupus erythematosus	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/> Age, OR	<input type="text"/> Year	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>																																																																				
Chronic rheumatic heart disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/> Age, OR	<input type="text"/> Year	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>																																																																				
<div style="border: 1px solid black; border-radius: 15px; padding: 5px; display: inline-block; margin-bottom: 5px;"> If No or Don't Know Go To 2A4.1 </div>																																																																													
<table border="1"> <thead> <tr> <th rowspan="2"></th> <th colspan="3">a. Was this condition diagnosed by a doctor?</th> <th colspan="2">b. When were you first diagnosed?</th> <th colspan="3">c. Did you receive treatment for this condition?</th> <th rowspan="2">d. If yes, what type of treatment?</th> </tr> <tr> <th>Yes</th> <th>No</th> <th>Don't Know</th> <th>Age, OR</th> <th>Year</th> <th>Yes</th> <th>No</th> <th>Don't Know</th> </tr> </thead> <tbody> <tr> <td>Thyroid disease. IF YES, Was it...</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Grave's disease</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="text"/> Age, OR</td> <td><input type="text"/> Year</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="text"/></td> </tr> <tr> <td>Hashimoto's thyroiditis</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="text"/> Age, OR</td> <td><input type="text"/> Year</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="text"/></td> </tr> <tr> <td>Hypothyroidism</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="text"/> Age, OR</td> <td><input type="text"/> Year</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="text"/></td> </tr> <tr> <td>Other type of thyroid disease (please specify): <input type="text"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="text"/> Age, OR</td> <td><input type="text"/> Year</td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="radio"/></td> <td><input type="text"/></td> </tr> </tbody> </table>											a. Was this condition diagnosed by a doctor?			b. When were you first diagnosed?		c. Did you receive treatment for this condition?			d. If yes, what type of treatment?	Yes	No	Don't Know	Age, OR	Year	Yes	No	Don't Know	Thyroid disease. IF YES, Was it...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>							Grave's disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/> Age, OR	<input type="text"/> Year	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	Hashimoto's thyroiditis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/> Age, OR	<input type="text"/> Year	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	Hypothyroidism	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/> Age, OR	<input type="text"/> Year	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	Other type of thyroid disease (please specify): <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/> Age, OR	<input type="text"/> Year	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>
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[Provide Extra Comments](#)

2A4.1	Excluding the last three months, have you ever been told by doctor that you have a tumor or cancer?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know
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If No or Don't Know Go to 2B.1

[Provide Extra Comments](#)

If yes, please specify

2A4.2a	a. Site of tumour:	
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2A4.2c	c. Was it a benign or malignant tumour?	<input type="radio"/> Benign <input type="radio"/> Malignant <input type="radio"/> DK
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2A4.2d	d. If skin cancer, was it melanoma or non-melanoma?	<input type="radio"/> Melanoma <input type="radio"/> Non-Melanoma <input type="radio"/> DK <input type="radio"/> Not applicable - not skin cancer
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2A4.2e	e. When were you first diagnosed?	<input type="text"/> AGE , OR <input type="text"/> YEAR
--------	-----------------------------------	---

2A4.3	If yes, do you remember if you were treated with:		
	Yes	No	Don't Know
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Radiotherapy?	<input type="radio"/>	<input type="radio"/>
	Chemotherapy?	<input type="radio"/>	<input type="radio"/>
	Surgery?	<input type="radio"/>	<input type="radio"/>
	other treatment, please specify <input style="width: 100px;" type="text"/>	<input type="radio"/>	<input type="radio"/>

[Provide Extra Comments](#)

If No or Don't Know, Go To 2B.1

2A5.1	Have you ever been told by doctor that you have any other tumour or cancer?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know
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[Provide Extra Comments](#)

If yes, please specify

2A5.2a	a. Site of tumour:		
2A5.2c	c. Was it a benign or malignant tumour?	<input type="radio"/> Benign <input type="radio"/> Malignant <input type="radio"/> DK	
2A5.2d	d. If skin cancer, was it melanoma or non-melanoma?	<input type="radio"/> Melanoma <input type="radio"/> Non-Melanoma <input type="radio"/> DK <input type="radio"/> Not applicable - not skin cancer	
2A5.2e	e. When were you first diagnosed?	<input type="text"/> AGE , OR <input type="text"/> YEAR	
2A5.3	If yes, do you remember if you were treated with:		
	Yes	No	Don't Know
Radiotherapy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chemotherapy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Surgery?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
other treatment, please specify <input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

[Provide Extra Comments](#)

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>>

B. BLOOD TRANSFUSION

2B.1 Have you ever received a blood transfusion more than one year ago? (This would include all kinds of transfusions, such as red cells, plasma or other blood derivatives)?

Yes
 No
 Don't Know

If No or Don't Know, Go To 2C.1

[Provide Extra Comments](#)

<< >>

2B.2 If yes, what (is/were) the reason(s), how many did you receive, and when was your first transfusion for (this/each) reason? DK

2B.2	a. Reason	b. Total number of transfusions for this reason	c. Age OR year of first transfusion	
1	<input type="text"/>	<input type="text"/>	<input type="text"/> Age	<input type="text"/> Year
2	<input type="text"/>	<input type="text"/>	<input type="text"/> Age	<input type="text"/> Year
3	<input type="text"/>	<input type="text"/>	<input type="text"/> Age	<input type="text"/> Year
4	<input type="text"/>	<input type="text"/>	<input type="text"/> Age	<input type="text"/> Year
5	<input type="text"/>	<input type="text"/>	<input type="text"/> Age	<input type="text"/> Year
6	<input type="text"/>	<input type="text"/>	<input type="text"/> Age	<input type="text"/> Year
7	<input type="text"/>	<input type="text"/>	<input type="text"/> Age	<input type="text"/> Year
8	<input type="text"/>	<input type="text"/>	<input type="text"/> Age	<input type="text"/> Year

[Provide Extra Comments](#)

<< >>

NOTE: CAPI has fields to enter up to 8 different transfusions

C. HOSPITALIZATION AND SURGICAL HISTORY

2C.1	(Apart from the current admission) Have you ever been admitted to a hospital?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know
------	---	---

If No or Don't Know, Go To 2D.1

[Provide Extra Comments](#)

<< >>

2C.2	If yes, do you remember why and when you were admitted?	<input type="checkbox"/> DK
------	---	-----------------------------

2C.2	If yes, do you remember why and when you were admitted?		
	a. Reasons for Hospitalization	b. Age	or year
1	<input type="text"/>	<input type="text"/> Age	<input type="text"/> Year
2	<input type="text"/>	<input type="text"/> Age	<input type="text"/> Year
3	<input type="text"/>	<input type="text"/> Age	<input type="text"/> Year
4	<input type="text"/>	<input type="text"/> Age	<input type="text"/> Year
5	<input type="text"/>	<input type="text"/> Age	<input type="text"/> Year
6	<input type="text"/>	<input type="text"/> Age	<input type="text"/> Year
7	<input type="text"/>	<input type="text"/> Age	<input type="text"/> Year
8	<input type="text"/>	<input type="text"/> Age	<input type="text"/> Year

[Provide Extra Comments](#)

<< >>

CAPI NOTE: The CAPI has fields for 8 different hospitalizations.

2C.3	Did you have any type of surgical procedure or biopsy carried out at any time up until one year ago in your life?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know
------	---	---

If No or Don't Know, Go To 2D.1

[Provide Extra Comments](#)

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For Females:

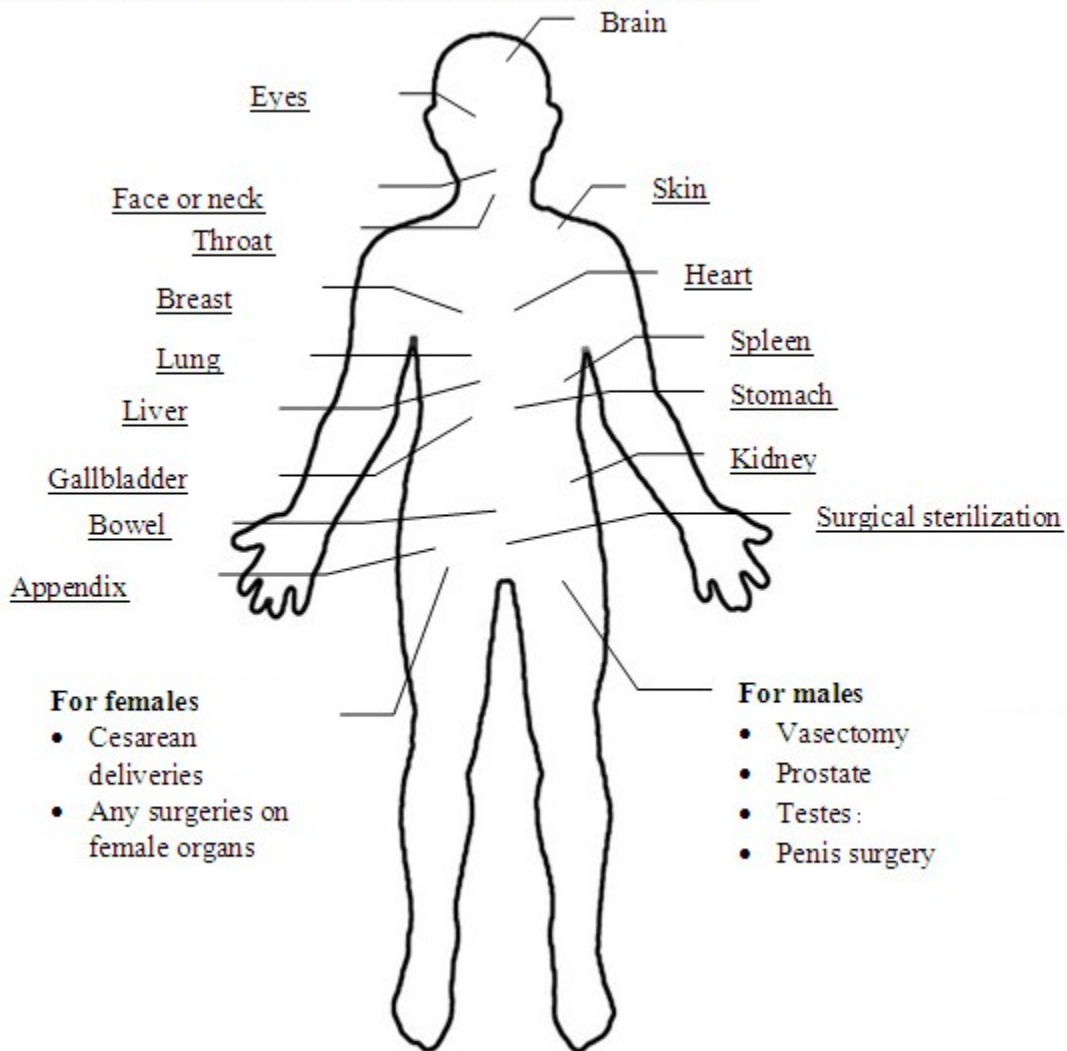
2C.4	<p>How many total surgical procedures and biopsies did you undergo up until one year ago? Please <u>include</u> surgery involving biopsies or removal of growths from the skin, eyes, brain, face or neck, throat, breast, heart, lung, spleen, kidney, surgical sterilization, liver, gallbladder, appendix, stomach, bowel, bone or any other type of surgery. <u>Do not</u> include any surgical procedures for your current admission, normal deliveries of a baby in a hospital, and <u>do not</u> include any dental surgeries.</p> <p>For females, include cesarean section deliveries and any surgeries on female organs.</p>	<ul style="list-style-type: none"> <input type="radio"/> 1 to 3 <input type="radio"/> 4 to 6 <input type="radio"/> 7 to 9 <input type="radio"/> 10 to 12 <input type="radio"/> 13 to 16 <input type="radio"/> 17 to 19 <input type="radio"/> 20 to 23 <input type="radio"/> 24 to 26 <input type="radio"/> 27 or more <input type="radio"/> DK
------	---	--

For Males

2C.4	<p>How many total surgical procedures and biopsies did you undergo up until one year ago? Please <u>include</u> surgery involving biopsies or removal of growths from the skin, eyes, brain, face or neck, throat, breast, heart, lung, spleen, kidney, surgical sterilization, liver, gallbladder, appendix, stomach, bowel, bone or any other type of surgery. <u>Do not</u> include any surgical procedures for your current admission, normal deliveries of a baby in a hospital, and <u>do not</u> include any dental surgeries.</p> <p>For males, include vasectomy, prostate, testes, and penis surgery.</p>	<ul style="list-style-type: none"> <input type="radio"/> 1 to 3 <input type="radio"/> 4 to 6 <input type="radio"/> 7 to 9 <input type="radio"/> 10 to 12 <input type="radio"/> 13 to 16 <input type="radio"/> 17 to 19 <input type="radio"/> 20 to 23 <input type="radio"/> 24 to 26 <input type="radio"/> 27 or more <input type="radio"/> DK
------	---	--

Surgical History

How many total surgical procedures and biopsies did you undergo?



Please include surgery involving biopsies or removal of growths from the skin, eyes, brain, face or neck, throat, breast, heart, lung, spleen, kidney, surgical sterilization, liver, gallbladder, appendix, stomach, bowel, bone or any other type of surgery.

For females, include cesarean section deliveries and any surgeries on female organs. For males, include vasectomy, prostate, testes, and penis surgery.

D. DENTAL SURGERIES AND HISTORY

2D.1	Did you ever have any dental surgeries? Please include surgery to pull wisdom teeth and other teeth, root canal, gum surgery, and any other types of dental surgery.	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know
------	--	---

If No or Don't Know, Go To 2D.3

[Provide Extra Comments](#)

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2D.2	How many total dental surgeries did you undergo?	<input type="radio"/> 1 to 3 <input type="radio"/> 4 to 6 <input type="radio"/> 7 to 9 <input type="radio"/> 10 to 12 <input type="radio"/> 13 to 16 <input type="radio"/> 17 to 19 <input type="radio"/> 20 to 23 <input type="radio"/> 24 to 26 <input type="radio"/> 27 or more <input type="radio"/> DK
------	--	--

[Provide Extra Comments](#)

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2D.3	How many of your permanent teeth ever became loose and then fell out or were pulled? This includes all teeth that fell out, or were pulled for pain, or lost for any reason, other than trauma.	<input type="text"/> # of teeth that fell out or were pulled
------	---	--

2D.4	As an adult, do your gums bleed regularly when you brush your teeth?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't brush teeth regularly <input type="radio"/> DK
------	--	--

[Provide Extra Comments](#)

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E. ACUPUNCTURE HISTORY

2E.1	Have you ever had acupuncture performed on you?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know
------	---	---

If No or Don't Know, Go To Section F

[Provide Extra Comments](#)

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2E.2	How old were you when you first had acupuncture?	<input type="text"/> Age OR <input type="text"/> Year
------	--	---

2E.3	How many times have you had acupuncture in your lifetime? Was it ...	<input type="radio"/> Only once <input type="radio"/> Between 2 and 10 times <input type="radio"/> More than 10 times during your lifetime <input type="radio"/> DK
------	---	--

[Provide Extra Comments](#)

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F. FAMILY HISTORY OF CANCER

Next we have some questions asking if any of your family members were diagnosed with cancer. These questions only apply to your biological or "blood" relatives, both living and deceased, including your mother, father, or any of your sisters, brothers, daughters or sons. Please **do not include** adoptive or step-parents or adopted or step-children or half-siblings. If you are unsure about how to answer these questions, try to provide as much information as you can recall. For example, if you do not know an exact age of diagnosis, an estimate such as "late 40s" is still helpful. If you cannot even estimate a response, just say "Don't know."

Now, have any of your living or deceased family members ever been diagnosed with any of the following cancers?

[Provide Extra Comments](#)

2F1.1	Have any of your living or deceased family members ever been diagnosed with Hodgkin lymphoma		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know		
<div style="border: 1px solid black; border-radius: 15px; padding: 5px; display: inline-block;"> If No or Don't Know, Go To 2F1.2 </div>					
2F1.1	a. Which relatives were affected?	b. What was the subtype or site, if known?	c. What was (his/her) age at diagnosis?	d. (IF DK AGE) What was (his/her) age range at diagnosis?	
				Start Age	End Age
	Select Answer	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Your mother	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Your father	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Your sisters	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Your brothers	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Your daughters	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Your sons	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

[Provide Extra Comments](#)

2F1.2	Have any of your living or deceased family members ever been diagnosed with Non-Hodgkin lymphoma		<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know		
<div style="border: 1px solid black; border-radius: 15px; padding: 5px; display: inline-block;"> If No or Don't Know, Go To 2F1.3 </div>					
2F1.2	a. Which relatives were affected?	b. What was the subtype or site, if known?	c. What was (his/her) age at diagnosis?	d. (IF DK AGE) What was (his/her) age range at diagnosis?	
				Start Age	End Age
	Select Answer	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Your mother	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Your father	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Your sisters	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Your brothers	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Your daughters	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
	Your sons	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

[Provide Extra Comments](#)

2F1.3 Have any of your living or deceased family members ever been diagnosed with **Leukemia** Yes No Don't Know

If No or Don't Know, Go To 2F1.4

2F1.3

a. Which relatives were affected?	b. What was the subtype or site, if known?	c. What was (his/her) age at diagnosis?	d. (IF DK AGE) What was (his/her) age range at diagnosis?	
			Start Age	End Age
Select Answer	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Your mother	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Your father	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Your sisters	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Your brothers	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Your daughters	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Your sons	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

[Provide Extra Comments](#)

<< >>

2F1.4 Have any of your living or deceased family members ever been diagnosed with **Multiple Myeloma** Yes No Don't Know

If No or Don't Know, Go To 2F1.5

2F1.4

a. Which relatives were affected?	b. What was the subtype or site, if known?	c. What was (his/her) age at diagnosis?	d. (IF DK AGE) What was (his/her) age range at diagnosis?	
			Start Age	End Age
Select Answer	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Your mother	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Your father	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Your sisters	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Your brothers	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Your daughters	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Your sons	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

[Provide Extra Comments](#)

<< >>

2F1.5 Have any of your living or deceased family members ever been diagnosed with **Lymphoma, unspecified** Yes No Don't Know

If No or Don't Know, Go To 2F.2

2F1.5

a. Which relatives were affected?	b. What was the subtype or site, if known?	c. What was (his/her) age at diagnosis?	d. (IF DK AGE) What was (his/her) age range at diagnosis?	
			Start Age	End Age
Select Answer	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Your mother	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Your father	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Your sisters	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Your brothers	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Your daughters	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Your sons	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

[Provide Extra Comments](#)

<< >>

2F.2 Have any family members been diagnosed with any other cancer? Yes No Don't Know

If No or Don't Know, Go To INTRO for 3A.1

[Provide Extra Comments](#)

<< >>

2F.2 a- e	a. (IF YES) What type of cancer or what was the site, if known?	b. Which relatives were affected?	c. What was the subtype or site, if known?	d. What was (his/her) age at diagnosis?	e. (IF DK AGE) What was (his/her) age range at diagnosis?	
					Start Age	End Age
1	<input type="text"/>	Select Answer	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	Your mother	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	Your father	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	Your sisters	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
5	<input type="text"/>	Your brothers	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
6	<input type="text"/>	Your daughters	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
7	<input type="text"/>	Your sons	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
8	<input type="text"/>	Select Answer	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
9	<input type="text"/>	Select Answer	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
10	<input type="text"/>	Select Answer	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
11	<input type="text"/>	Select Answer	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
12	<input type="text"/>	Select Answer	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
13	<input type="text"/>	Select Answer	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
14	<input type="text"/>	Select Answer	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
15	<input type="text"/>	Select Answer	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
16	<input type="text"/>	Select Answer	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

[Provide Extra Comments](#)

<< >>

CAPI has fields to enter up to 16 family members

INTRO for 3A.1

A. OUTDOOR ACTIVITIES RESULTING IN EXPOSURE TO SUN

I would like you to tell me about how much time you spent doing outdoor activities that result in you being exposed to the sun.

3A.1	When you were in your teens (ages 13-19) , in the summer (May through September) between the hours of 9 AM and 5 PM:	a. Monday to Friday (or school or work days)					b. Saturday					c. Sunday							
		< 0.5	0.5 to < 1 hour	1 to < 2 hours	2 to < 4 hours	4 or more hours	DK	< 0.5	0.5 to < 1 hour	1 to < 2 hours	2 to < 4 hours	4 or more hours	DK	< 0.5	0.5 to < 1 hour	1 to < 2 hours	2 to < 4 hours	4 or more hours	DK
	3A.1 How many hours did you usually spend in the sun...?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3A.2		a. Monday to Friday (or school or work days)					b. Saturday					c. Sunday							
		Never	>0- <25%	25- <50%	50- <75%	>= 75% of the time	DK	Never	>0- <25%	25- <50%	50- <75%	>= 75% of the time	DK	Never	>0- <25%	25- <50%	50- <75%	>= 75% of the time	DK
	3A.2 On sunny days, when you were outdoors, how often did you protect yourself from the sun (e.g., wear a hat or long-sleeve shirt or sunscreen or use a parasol)? Was it...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

[Provide Extra Comments](#)



3A.3	When you were in your twenties and thirties , in the summer (May through September) between the hours of 9 AM and 5 PM:	a. Monday to Friday (or school or work days)					b. Saturday					c. Sunday							
		< 0.5	0.5 to < 1 hour	1 to < 2 hours	2 to < 4 hours	4 or more hours	DK	< 0.5	0.5 to < 1 hour	1 to < 2 hours	2 to < 4 hours	4 or more hours	DK	< 0.5	0.5 to < 1 hour	1 to < 2 hours	2 to < 4 hours	4 or more hours	DK
	3A.3 How many hours did you usually spend in the sun...?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3A.4		a. Monday to Friday (or school or work days)					b. Saturday					c. Sunday							
		Never	>0- <25%	25- <50%	50- <75%	>= 75% of the time	DK	Never	>0- <25%	25- <50%	50- <75%	>= 75% of the time	DK	Never	>0- <25%	25- <50%	50- <75%	>= 75% of the time	DK
	3A.4 On sunny days, when you were outdoors, how often did you protect yourself from the sun (e.g., wear a hat or long-sleeve shirt or sunscreen or use a parasol)? Was it...	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

IF SUBJECT IS LESS THAN AGE 40, Go To Section 3B.
 IF SUBJECT IS AGE 40-49, begin next question with "Since you became age 40, in the summer months..."
 IF SUBJECT IS AGE 50+ ask the next question as shown below.

3A.5	In the last ten years, in the summer (May through September) between the hours of 9 AM and 5 PM:	a. Monday to Friday (or school or work days)						b. Saturday						c. Sunday					
		< 0.5	0.5 to < 1 hour	1 to < 2 hours	2 to < 4 hours	4 or more hours	DK	< 0.5	0.5 to < 1 hour	1 to < 2 hours	2 to < 4 hours	4 or more hours	DK	< 0.5	0.5 to < 1 hour	1 to < 2 hours	2 to < 4 hours	4 or more hours	DK
	3A.5 How many hours did you usually spend in the sun...?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3A.6	3A.6 On sunny days, when you were outdoors, how often did you protect yourself from the sun (e.g., wear a hat or long-sleeve shirt or sunscreen or use a parasol)? Was it...	a. Monday to Friday (or school or work days)						b. Saturday						c. Sunday					
		Never	>0- <25%	25- <50%	50- <75%	>= 75% of the time	DK	Never	>0- <25%	25- <50%	50- <75%	>= 75% of the time	DK	Never	>0- <25%	25- <50%	50- <75%	>= 75% of the time	DK
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

[Provide Extra Comments](#)



B.USE OF HAIR DYE

3B.1

Have you ever used hair dye or any hair colouring product regularly?

- Yes
- No
- Don't Know

If No or Don't Know, Go To 3C.1

[Provide Extra Comments](#)

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If still using Go To 2a etc.

3B.2

ASK 3B.2a THROUGH 3B.2f FOR EACH PERIOD OF USE (#1, 2, 3, ETC.)

	a. How old were you (first/next) used hair dye or any hair colouring product?		b. What type, that is, permanent, semi permanent, or temporary, did you use? (See description of types below)			c. What colour was this particular hair colouring product?	Other Color:	d. How many times per year did you use it?	e. Did you use it for colouring all your hair or just for highlights?		f. How old were you when you stopped using this particular hair colouring product?		Still using it?	Clean Answer
	Age	Year	Permanent	Semi-permanent	Temporary				Complete	Highlight	Age	Year		
#1	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Select Answer	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
#2	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Black	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
#3	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Blonde/Lt brown	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
#4	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Dk Brown	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
#5	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Red	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
#6	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
#7	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Select answer	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
#8	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Select answer	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
#9	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Select answer	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
#10	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Select answer	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
#11	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Select answer	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
#12	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Select answer	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
#13	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Select answer	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
#14	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Select answer	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
#15	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Select answer	<input type="text"/>	<input type="text"/>	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

- Select Answer
- Black
- Blonde/Lt brown
- Dk Brown
- Red
- Other

Do you have any more row to add? If yes, please click here!!

NOTE: In CAPI room for 15 different hair dyes or any hair colouring products

* "type" descriptions:

1. Permanent : products that do not wash out after repeated shampoos and leave a line as they grow out
2. Semi-permanent : products that wash out in 6-10 shampoos
3. Temporary : products that wash out in 1 shampoo

[Provide Extra Comments](#)

<< >>

C. SLEEP DURATION AND QUALITY

I would now like to ask about your sleeping habits and quality of sleep during two different periods of your adult life.

First, when you were in your **20s** and **30s**...

3C.1	On average, how many hours did you usually sleep each night?	<input type="text"/> hours
3C.2	How well did you usually sleep then?	<input type="radio"/> Very well <input type="radio"/> Fairly well <input type="radio"/> Fairly poorly <input type="radio"/> Poorly <input type="radio"/> Cannot say
3C.3	When you were in your 20s and 30s , on average, how many hours of sleep did you usually need during the night to be in good working condition the next day?	<input type="text"/> hours
3C.4	Did you usually nap (at least 3 days a week) during the day when you were in your 20s and 30s ?	<input type="radio"/> Yes <input type="radio"/> No

If No, Go To 3C.6

[Provide Extra Comments](#)

<< >>

3C.5	How long, on average, did you usually nap during the day?	<input type="text"/> Minutes OR <input type="text"/> hours
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[Provide Extra Comments](#)

<< >>

3C.6	Did you usually (more than one time per week), take medication or a supplement to help you sleep then? If so, what type?	<input type="radio"/> Yes (specify type) <input type="text"/> <input type="radio"/> No
------	--	---

[Provide Extra Comments](#)

<< >>

IF SUBJECT IS LESS THAN AGE 40, Go To SECTION 3D INTRO.
 IF SUBJECT IS AGE 40-49, Continue.
 IF SUBJECT IS AGE 50+, include "and fifties" in 3C.7 INTRO and 3C.9

Next, when you were in your **40s** and **50s**...

3C.7	On average, how many hours did you usually sleep each night?	<input type="text"/> hours
3C.8	How well did you usually sleep then?	<input type="radio"/> Very well <input type="radio"/> Fairly well <input type="radio"/> Fairly poorly <input type="radio"/> Poorly <input type="radio"/> Cannot say
3C.9	When you were in your 40s and 50s , on average, how many hours of sleep did you usually need during the night to be in good working condition the next day?	<input type="text"/> hours
3C.10	Did you usually nap (at least 3 days a week) during the day when you were in your 40s and 50s ?	<input type="radio"/> Yes <input type="radio"/> No

If No, Go To 3C.12

[Provide Extra Comments](#)

<< >>

3C.11	How long, on average, did you usually nap during the day?	<input type="text"/> Minutes OR <input type="text"/> hours
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[Provide Extra Comments](#)

<< >>

3C.12	Did you usually (more than one time per week), take medication or a supplement to help you sleep then? If so, what type?	<input type="radio"/> Yes (specify type) <input type="text"/> <input type="radio"/> No
-------	--	---

[Provide Extra Comments](#)

<< >>

D. USUAL PHYSICAL ACTIVITY

3D.1 When you were in **your teens (ages 13-19)**, on average, how many hours in a day did you spend in the following activities, either as work or leisure, from.?

	Hours per day	
	...Monday to Friday (or school or work days)	...Saturday to Sunday (weekends or holidays)
Sleeping	<input type="text"/>	<input type="text"/>
Sitting Activity: driving car, eating, reading, homework, desk work, watching TV, listening to radio, sewing, playing cards and games, office work.	<input type="text"/>	<input type="text"/>
Light Activity: leisure, light housework, strolling, personal care, standing, dancing, yoga.	<input type="text"/>	<input type="text"/>
Moderate Activity: heavy housework; looking after younger brothers and sisters and other children; light sports; yard work; bicycling on level ground, tai chi, chi kung, walking on level ground.	<input type="text"/>	<input type="text"/>
Vigorous Activity: farm work; heavy carpentry, moving heavy furniture, loading or unloading trucks, shoveling or other equivalent manual work; strenuous sports.	<input type="text"/>	<input type="text"/>
=	0.0	0.0

[Provide Extra Comments](#)

3D.2 As an adult, **from age 20 up until 10 years ago**, on average, how many hours in a day did you spend in the following activities, either as work or leisure, from...?

	Hours per day	
	...Monday to Friday (or school or work days)	...Saturday to Sunday (weekends or holidays)
Sleeping	<input type="text"/>	<input type="text"/>
Sitting Activity: driving car, eating, reading, homework, desk work, watching TV, listening to radio, sewing, playing cards and games, office work.	<input type="text"/>	<input type="text"/>
Light Activity: leisure, light housework, strolling, personal care, standing, dancing, yoga.	<input type="text"/>	<input type="text"/>
Moderate Activity: heavy housework; looking after younger brothers and sisters and other children; light sports; yard work; bicycling on level ground, tai chi, chi kung, walking on level ground.	<input type="text"/>	<input type="text"/>
Vigorous Activity: farm work; heavy carpentry, moving heavy furniture, loading or unloading trucks, shoveling or other equivalent manual work; strenuous sports.	<input type="text"/>	<input type="text"/>
=	0.0	0.0

[Provide Extra Comments](#)

3D.3 Thinking back on your overall level of physical activity, throughout your adult years from age 20 up until 10 years ago, would you describe yourself as either:

- Highly active
- Moderately active
- Moderately inactive
- Highly inactive

[Provide Extra Comments](#)

If subject is less than 30 years old, ask 3D.3It30

3D.3It30 Thinking back on your overall level of physical activity, throughout your adult years up to 2 years ago, would you describe yourself as either:

- Highly active
- Moderately active
- Moderately inactive
- Highly inactive

[Provide Extra Comments](#)

E. DIET AND BEVERAGES

Next I would like to ask about your usual eating and beverage use habits, first as an adult, before one year ago and not including any recent dietary changes. Please tell me how often you ate or drank each of the following products, both at home and outside the home.

3E.1 ~ 3E.8		As an adult, how often did you usually (drink/eat).								
		Never or less than once a year	At least once a year but less than once a month	1-3 times a month	Once a week	2-3 times a week	4-6 times a week	Once a day	2 times a day	3 or more times a day
	Green leafy vegetables, including spinach and bok choy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Fresh fruit	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Soy milk, or powdered soy milk	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Fried bean curd, vegetarian chicken, bean curd cake and other kinds of bean products excluding fresh bean curd	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
		Never or less than once a year	At least once a year but less than once a month	1-3 times a month	Once a week	2-3 times a week	4-6 times a week	Once a day	2 times a day	3 or more times a day
	Fresh bean curd	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Mung bean, red bean and other dried beans	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Soybean sprouts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	Mung bean sprouts	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

[Provide Extra Comments](#)

Next select the category that best describes how often you usually drank each tea or coffee beverage as an adult, before one year ago and not including any recent changes. I would also like to know how much you usually drank each time. Include consumption at home and outside the home.

3E.9 ~ 3E.14 As an adult, how often did you usually drink...

	Never or less than once a year	At least once a year but less than once a month	1-3 times a month	Once a week	2-3 times a week	4-6 times a week	Once a day	2 times a day	3 or more times a day
Tea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Jasmine tea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Green tea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Oolong (Ti Kuan Yin) tea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Black (Pu'er) tea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ceylon tea/Sri Lanka black tea or western red tea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coffee	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

[Provide Extra Comments](#)



Please tell me how often you ate each of following types of fish before one year ago and not including any recent changes (including fish eaten at home and outside the home.)

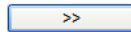
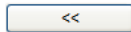
3E.15 ~ 3E.17 First, as an adult, how often did you usually eat.

	Never or less than once a year	At least once a year but less than once a month	1-3 times a month	Once a week	2-3 times a week	4-6 times a week	Once a day	2 times a day	3 or more times a day
Guangdong moldy fragrant salted fish?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Guangdong firm salted fish?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other types of salted fish? IF YES, PLEASE SPECIFY TYPES:									
SPECIFY (1) <input type="text" value="clean this"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SPECIFY (2) <input type="text" value="clean this"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3E.18 ~
3E.20

	Next, as a child, how often did you usually eat.								
	Never or less than once a year	At least once a year but less than once a month	1-3 times a month	Once a week	2-3 times a week	4-6 times a week	Once a day	2 times a day	3 or more times a day
Guangdong moldy fragrant salted fish?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Guangdong firm salted fish?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other types of salted fish?									
SPECIFY (1) <input type="text" value="clean this"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SPECIFY (2) <input type="text" value="clean this"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

[Provide Extra Comments](#)



F. SMOKING

3F.1	Have you ever smoked regularly (at least 1 cigarette on most days) for at least half a year (6 months)?	<input type="radio"/> Yes <input type="radio"/> No	If No, Go To 3G.1
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[Provide Extra Comments](#)

3F.2	How old were you when you started smoking?	<input type="text"/> AGE OR <input type="text"/> YEAR
------	--	---

3F.3	Do you smoke cigarettes regularly now?	<input type="radio"/> Yes <input type="radio"/> No	If Yes, Go To 3F.6
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[Provide Extra Comments](#)

If No,
Go To 3F.4

3F.4	How old were you when you stopped smoking cigarettes regularly?	<input type="text"/> AGE OR <input type="text"/> YEAR
------	---	---

3F.5	Thinking about all the years that you smoked before you stopped, about how many cigarettes per day did you usually smoke?	<input type="radio"/> 10 or less <input type="radio"/> 11-20 <input type="radio"/> 21-30 <input type="radio"/> 31 or more	Go To 3F.12
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[Provide Extra Comments](#)

3F.6	How many cigarettes per day do you usually smoke?	<input type="radio"/> 10 or less <input type="radio"/> 11-20 <input type="radio"/> 21-30 <input type="radio"/> 31 or more
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3F.7	How soon after you wake up do you smoke your first cigarette? Is it.	<input type="radio"/> Within 5 minutes <input type="radio"/> 6-30 minutes <input type="radio"/> 31-60 minutes <input type="radio"/> After 60 minutes
------	--	---

3F.8	Do you find it difficult to refrain from smoking in places where it is forbidden, for example, in church, at the library, in the cinema, etc.?	<input type="radio"/> Yes <input type="radio"/> No
------	--	---

3F.9	Which cigarette would you hate most to give up? Is it.	<input type="radio"/> The first one in the morning <input type="radio"/> Any other
------	--	---

3F.10	Do you smoke more frequently during the first hours after awakening than during the rest of the day?	<input type="radio"/> Yes <input type="radio"/> No
-------	--	---

3F.11	Do you smoke if you are so ill that you are in bed most of the day?	<input type="radio"/> Yes <input type="radio"/> No
-------	---	---

[Provide Extra Comments](#)

3F.12	Do you smoke a water pipe regularly now?	<input type="radio"/> Yes <input type="radio"/> No	If No, Go To 3F.14
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[Provide Extra Comments](#)

3F.13	How many shi lang per month do you smoke? (1 SHI LANG = 50 GRAMS)	<input type="text"/> SHILANG PER MONTH
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[Provide Extra Comments](#)

3F.14	Do you smoke cigars regularly now?	<input type="radio"/> Yes <input type="radio"/> No	If No, Go To 3F.16
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[Provide Extra Comments](#)

<< >>

3F.15	How many cigars per month do you smoke?	<input type="text"/> CIGARS PER MONTH
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[Provide Extra Comments](#)

<< >>

3F.16	Have you ever chewed tobacco?	<input type="radio"/> Yes <input type="radio"/> No	If No, Go To 3G.1
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[Provide Extra Comments](#)

<< >>

3F.17	How many years (have you used/did you use) chewing tobacco?	<input type="text"/> years
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3F.18	What type of chewing tobacco (do/did) you use?	<input type="text"/>
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[Provide Extra Comments](#)

<< >>

G. ALCOHOL INTAKE

3G.1	Have you ever drunk alcohol (such as beer, rice wine, or spirits/hard liquor) more than once a month, on average?	<input type="radio"/> Yes <input type="radio"/> No	If No, Go To 3H CAPI NOTE
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[Provide Extra Comments](#)

3G.2	How old were you when you started drinking one or more times per month.	<input type="text"/> AGE	OR,	<input type="text"/> Year
------	---	--------------------------	-----	---------------------------

[Provide Extra Comments](#)

3Ga.1	a. How often do or did you drink Beer ?	<input type="radio"/> Never to less than 12 times a year <input type="radio"/> At least once a month, but less than 4 times per month <input type="radio"/> At least once a week, or more. <input type="radio"/> Please specify: # of times per week <input style="width: 50px;" type="text"/>
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If Never,
 Go To
 3Ga.2

3Gb.1	Each time you drank, how many drinks, on average did you have?	1 <input style="width: 30px;" type="text"/> glasses each time 2 <input style="width: 30px;" type="text"/> cans each time 3 <input style="width: 30px;" type="text"/> small bottles each time (250-400ml) 4 <input style="width: 30px;" type="text"/> large bottles each time (>=500ml) 5 <input style="width: 30px;" type="text"/> liang each time
-------	--	--

ENTER DECIMALS FOR LESS THAN ONE DRINK (E.G., ONE-HALF BOTTLE = 0.5)

[Provide Extra Comments](#)

3Ga.2	a. How often do or did you drink Rice wine ?	<input type="radio"/> Never to less than 12 times a year <input type="radio"/> At least once a month, but less than 4 times per month <input type="radio"/> At least once a week, or more. <input type="radio"/> Please specify: # of times per week <input style="width: 50px;" type="text"/>
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If Never,
 Go To
 3Ga.3

3Gb.2	Each time you drank, how many drinks, on average did you have?	1 <input style="width: 30px;" type="text"/> glasses each time 2 <input style="width: 30px;" type="text"/> cans each time 3 <input style="width: 30px;" type="text"/> small bottles each time (250-400ml) 4 <input style="width: 30px;" type="text"/> large bottles each time (>=500ml) 5 <input style="width: 30px;" type="text"/> liang each time
-------	--	--

ENTER DECIMALS FOR LESS THAN ONE DRINK (E.G., ONE-HALF BOTTLE = 0.5)

[Provide Extra Comments](#)

If Never,
Go To
3Ga.5

3Ga.3	a. How often do or did you drink Red Grape Wine ?	<input type="radio"/> Never to less than 12 times a year <input type="radio"/> At least once a month, but less than 4 times per month <input type="radio"/> At least once a week, or more. Please specify: # of times per week <input type="text"/>
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3Gb.3	Each time you drank, how many drinks, on average did you have?	1 <input type="text"/> glasses each time 2 <input type="text"/> cans each time 3 <input type="text"/> small bottles each time (250-400ml) 4 <input type="text"/> large bottles each time (>=500ml) 5 <input type="text"/> liang each time
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ENTER DECIMALS FOR LESS THAN ONE DRINK (E.G., ONE-HALF BOTTLE = 0.5)
[Provide Extra Comments](#)

<< >>

If Never,
Go To 3Ga.4

3Ga.5	a. How often do or did you drink White Grape Wine ?	<input type="radio"/> Never to less than 12 times a year <input type="radio"/> At least once a month, but less than 4 times per month <input type="radio"/> At least once a week, or more. Please specify: # of times per week <input type="text"/>
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3Gb.5	Each time you drank, how many drinks, on average did you have?	1 <input type="text"/> glasses each time 2 <input type="text"/> cans each time 3 <input type="text"/> small bottles each time (250-400ml) 4 <input type="text"/> large bottles each time (>=500ml) 5 <input type="text"/> liang each time
-------	--	---

ENTER DECIMALS FOR LESS THAN ONE DRINK (E.G., ONE-HALF BOTTLE = 0.5)
[Provide Extra Comments](#)

<< >>

If Never,
Go To 3H CAPI
NOTE

3Ga.4	a. How often do or did you drink Spirits/ Hard liquor (e.g. brandy) ?	<input type="radio"/> Never to less than 12 times a year <input type="radio"/> At least once a month, but less than 4 times per month <input type="radio"/> At least once a week, or more. <input type="radio"/> Please specify: # of times per week <input type="text"/>
-------	--	--

3Gb.4	Each time you drank, how many drinks, on average did you have?	1 <input type="text"/> glasses each time 2 <input type="text"/> cans each time 3 <input type="text"/> small bottles each time (250-400ml) 4 <input type="text"/> large bottles each time (>=500ml) 5 <input type="text"/> liang each time
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ENTER DECIMALS FOR LESS THAN ONE DRINK (E.G., ONE-HALF BOTTLE = 0.5)
[Provide Extra Comments](#)

<< >>

CAPI NOTE: For Women Only; Skip to Part IV for Male Subjects.

H. REPRODUCTIVE HISTORY

3H.1	How old were you when you had your first period (menarche)? If you do not remember your age, then give an age range, for example 10-13.	<input type="text"/> AGE OR Age Range <input type="text"/> - <input type="text"/> <input type="checkbox"/> Never had a period <input type="checkbox"/> DK
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If Never had a period, Go To 3H.7

[Provide Extra Comments](#)

<< >>

3H.2	Did you typically have regular periods? Were they. ("Regular" means that you would know the approximate date of your next period every month.)	<input type="radio"/> Always regular <input type="radio"/> Regular most of the time, or <input type="radio"/> Quite iirregular
3H.3	How many days were there usually between the beginning of one period and the beginning of the next? (RECORD SINGLE NUMBER OR A RANGE)	<input type="text"/> # OF DAYS OR RANGE <input type="text"/> - <input type="text"/>
3H.4	How many days of flow did you usually have during a typical menstrual period? (RECORD SINGLE NUMBER OR A RANGE)	<input type="text"/> # OF DAYS OR RANGE <input type="text"/> - <input type="text"/>
3H.5	Do you still have periods? (Note: If you have gone through menopause, you will no longer have periods, and the response to this question should be "No".)	<input type="radio"/> Yes <input type="radio"/> No

If Yes, Go to 3H.7

[Provide Extra Comments](#)

<< >>

3H.6	How old were you when you stopped having periods for a year or more?	<input type="text"/> AGE OR Age Range <input type="text"/> - <input type="text"/> <input type="checkbox"/> DK
------	--	--

[Provide Extra Comments](#)

<< >>

3H.7	Have you ever been pregnant?	<input type="radio"/> Yes <input type="radio"/> No
------	------------------------------	---

If No, Go to PART IV

[Provide Extra Comments](#)

<< >>

3H.8	How many pregnancies have you had?	<input type="text"/> PREGNANCIES
3H.9	How many live births have you had?	<input type="text"/> LIVE BIRTHS
3H.10	How old were you when your (first) child was born?	<input type="text"/> AGE OR <input type="text"/> YEAR

If 0 pregnancies, Go To PART IV.

If 0 live births, Go To PART IV. If 3H.9 is 1, answer 3H.10 then Go To 3H.12

3H.11	How old were you when your last child was born?	<input type="text"/> AGE OR <input type="text"/> YEAR
3H.12	Did you breast feed (your baby/any of your babies)?	<input type="radio"/> Yes <input type="radio"/> No

If No, Go to PART IV

[Provide Extra Comments](#)

<< >>

3H.13	How many months did you usually (breast feed your baby/breast feed your babies)?	<input type="text"/> MONTHS
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[Provide Extra Comments](#)

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PART IV

A. OVERVIEW OF RESIDENTIAL HISTORY

Now we have some questions about the residences in which you lived. We will start with the first house you lived in when you were born, and proceed up to your current or last residence. Please tell me about all the places where you lived **for at least 2 years** or longer, including family residences or somewhere else, such as in a boarding school, institution or with friends.

Please include your current address in the residential history.

*****1st Address*****

4A.1a	Was the first house you lived in when you were born located in Taiwan, Hong Kong or Mainland China? (IF MAINLAND CHINA, ASK: Was this first house located in a village/rural area or in a city/urban area?)	<input type="radio"/> Taiwan	<input checked="" type="radio"/> Hong Kong	<input type="radio"/> China (Village)	<input type="radio"/> China (City)	<input type="radio"/> Other Country
		<input type="button" value="Clean answers"/>				

4A.2	ADDRESS	District : <input type="text"/>	Floor No: <input type="text"/>
<div style="border: 1px solid black; border-radius: 15px; padding: 5px; display: inline-block;">If Hong Kong selected, these are the address fields.</div>	Street Name :	<input type="text"/>	Room No. <input type="text"/>
	Street No :	<input type="text"/>	
	Building No :	<input type="text"/>	

4A.39	(START YEAR) During what year, or how old were you, when you first moved into this house?	<input type="text"/> YEAR	OR	<input type="text"/> AGE
-------	---	---------------------------	----	--------------------------

4A.40	(END YEAR): During what year, or how old were you, when you moved out of this house? IF LESS THAN 2 YEARS AFTER START YEAR, PROBE AND REVISE	<input type="text"/> YEAR	OR	<input type="text"/> AGE
-------	---	---------------------------	----	--------------------------

Are you still living here?

[Provide Extra Comments](#)

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The CAPI provides space for up to 10 childhood and adult residences.

B. CHILDHOOD RESIDENCE HISTORY

Now I will ask several questions about the characteristics and environment of each of your childhood residences you lived in for at least 2 years.

[Provide Extra Comments](#)

<< >>

Residence

Let's begin with the house you lived in after you were born, located in

[Provide Extra Comments](#)

<< >>

4B1.2	Did you live with your family or reside somewhere else, such as in a boarding school, institution or with friends?	<input type="radio"/> Family <input type="radio"/> Boarding School <input type="radio"/> Institution <input type="radio"/> Friends <input type="radio"/> Others
-------	--	---

If Family,
Go To
4B1.6

If Friends
or Others,
Go To
4B1.6

[Provide Extra Comments](#)

<< >>

4B1.3	How many <u>days per week</u> did you live in this boarding school or institution?	<input type="text"/> DAYS PER WEEK
4B1.4	How many <u>months per year</u> did you live in this boarding school or institution?	<input type="text"/> MONTHS PER YEAR
4B1.5	On average, how many people slept in the same dorm room with you? (Include yourself in the count.)	<input type="text"/> # SHARING SAME DORM ROOM

[Provide Extra Comments](#)

<< >>

If Sharing
Same Dorm
Room, Go To
4B1.10
INTRO

4B1.6	How many rooms were in this house?	<input type="text"/> # ROOMS
4B1.7	What was the maximum number of people in the household? (Include yourself in the count.)	<input type="text"/> # HOUSEHOLD MEMBERS
4B1.8	How many people shared the same bedroom with you? (Include yourself in the count.)	<input type="text"/> # SHARING SAME BEDROOM
4B1.9	During the day, did you stay in a communal day care center?	<input type="radio"/> Yes <input type="radio"/> No

[Provide Extra Comments](#)

INTRO. 4B1.10

Residenc

The next questions ask about any animals that may have been kept in or near this house when you were living there in your childhood. First...

[Provide Extra Comments](#)

Check if this Residence was a Boarding School or Institution.
 If Yes, (4B1.2 = 2 OR 3), SKIP TO QUESTION 4B1.11.
 If No, (4B1.2 = 1, 4 OR 5), ASK QUESTION 4B1.10.

4B1.10	Were there any dogs, cats, birds or other animals that stayed inside the living area most of the time for at least 6 months?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know
--------	--	---

If No or Don't Know
 Go To 4B1.11

[Provide Extra Comments](#)

Q4B1.10.1a	What kinds of pets? Were there...Any dogs?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know
------------	--	---

If No or Don't Know
 Go To 4B1.10.2a

[Provide Extra Comments](#)

Q4B1.10.1b	b. How many? What was the maximum number of dogs kept inside this house at any one time?	<input type="text"/> TOTAL # OF DOGS
Q4B1.10.1c	c. How often did you feed and/or clean the dogs or the (cages/areas) where they were kept? Was it...	<input type="radio"/> Never <input type="radio"/> Occasionally <input type="radio"/> Daily

[Provide Extra Comments](#)

Q4B1.10.2a	Were there...Any cats?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know
------------	-------------------------------	---

If No or Don't Know
Go To 4B1.10.3a

[Provide Extra Comments](#)

Q4B1.10.2b	b. How many? What was the maximum number of cats kept inside this house at any one time?	<input type="text"/> TOTAL # OF CATS
Q4B1.10.2c	c. How often did you feed and/or clean the cats or the (cages/areas) where they were kept? Was it...	<input type="radio"/> Never <input type="radio"/> Occasionally <input type="radio"/> Daily

[Provide Extra Comments](#)

Q4B1.10.3a	Were there...Any pet birds?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know
------------	------------------------------------	---

If No or Don't Know
Go To 4B1.10.4a

[Provide Extra Comments](#)

Q4B1.10.3b	b. How many? What was the maximum number of pet birds kept inside this house at any one time?	<input type="text"/> TOTAL # OF PET BIRDS
Q4B1.10.3c	c. How often did you feed and/or clean the pet birds or the (cages/areas) where they were kept? Was it...	<input type="radio"/> Never <input type="radio"/> Occasionally <input type="radio"/> Daily

[Provide Extra Comments](#)

Q4B1.10.4a	Were there...Any other types of pets?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know
------------	--	---

If No or Don't Know
Go To 4B1.11

[Provide Extra Comments](#)

4B1.10.4aO1	Any other types of pets?(SPECIFY 1):	<input type="text"/>
4B1.10.4bO1	TOTAL # OF (SPECIFY 1)	<input type="text"/> TOTAL # OF (SPECIFY 1)
4B1.10.4cO1	c. How often did you feed and/or clean the [ANIMALS #1] or clean the areas where they were kept? Was it.	<input type="radio"/> Never <input type="radio"/> Occasionally <input type="radio"/> Daily
4B1.10.4aO2	(SPECIFY 2):	<input type="text"/>
4B1.10.4bO2	TOTAL # OF (SPECIFY 2)	<input type="text"/> TOTAL # OF (SPECIFY 2)
4B1.10.4cO2	c. How often did you feed and/or clean the [ANIMALS #2] or clean the areas where they were kept? Was it.	<input type="radio"/> Never <input type="radio"/> Occasionally <input type="radio"/> Daily

[Provide Extra Comments](#)

4B1.11	Were there any chickens, pigs or other animals which were raised for food or to make money, that either stayed inside this house or were kept near it (that is, within about 25 meters) for at least 6 months, when you were living there?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know
--------	--	---

If No or Don't Know,
 Go To 4B2.1

[Provide Extra Comments](#)

Go To "Check Response Instruction" following Section 4B1.11.4

4B1.11.1a	What kinds of animals? Were there...Any chickens?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know
-----------	---	---

If No or Don't Know,
 Go To 4B1.11.2a

[Provide Extra Comments](#)

4B1.11.1b	b. How many? What was the maximum number of chickens that were kept in or near this house at any one time?	<input type="text"/> TOTAL # OF CHICKENS
4B1.11.1c	c. How often did you feed the chickens and/or clean the areas where they were kept? Was it.	<input type="radio"/> Never <input type="radio"/> Occasionally <input type="radio"/> Daily
4B1.11.1d	d. Were you ever involved in slaughtering the chickens?	<input type="radio"/> Yes <input type="radio"/> No

[Provide Extra Comments](#)

4B1.11.2a	Were there....Any goats or sheep?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know
-----------	--	---

If No or Don't Know,
Go To 4B1.11.3a

[Provide Extra Comments](#)

4B1.11.2b	b. What was the maximum number of GOATS AND SHEEP that were kept in or near this house at any one time?	<input type="text"/> TOTAL # OF GOATS AND SHEEP
-----------	---	---

4B1.11.2c	c. How often did you feed the GOATS AND SHEEP and/or clean the areas where they were kept? Was it.	<input type="radio"/> Never <input type="radio"/> Occasionally <input type="radio"/> Daily
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4B1.11.2d	d. Were you ever involved in slaughtering the GOATS AND SHEEP?	<input type="radio"/> Yes <input type="radio"/> No
-----------	--	---

[Provide Extra Comments](#)

4B1.11.3a	Were there....Any pigs?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know
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If No or Don't Know,
Go To 4B1.11.4a

[Provide Extra Comments](#)

4B1.11.3b	b. What was the maximum number of PIGS that were kept in or near this house at any one time?	<input type="text"/> TOTAL # OF PIGS
-----------	--	--------------------------------------

4B1.11.3c	c. How often did you feed the PIGS and/or clean the areas where they were kept? Was it.	<input type="radio"/> Never <input type="radio"/> Occasionally <input type="radio"/> Daily
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4B1.11.3d	d. Were you ever involved in slaughtering the PIGS?	<input type="radio"/> Yes <input type="radio"/> No
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[Provide Extra Comments](#)

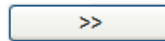
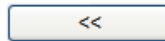
4B1.11.4a	Were there....Any big animals such as horses, cows, or cattle? IF YES, What kind of big animals?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know
-----------	---	---

If No or Don't Know,
Go To 4B2.1

[Provide Extra Comments](#)

4B1.11.4a01	(SPECIFY 1):	<input type="text"/>
4B1.11.4b1	TOTAL # OF (SPECIFY 1)	<input type="text"/> TOTAL # OF (SPECIFY 1)
4B1.11.4c01	c. How often did you feed the [ANIMALS #1] and/or clean the areas where they were kept? Was it.	<input type="radio"/> Never <input type="radio"/> Occasionally <input type="radio"/> Daily
4B1.11.4d01	d. Were you ever involved in slaughtering the [ANIMALS #1]?	<input type="radio"/> Yes <input type="radio"/> No
4B1.11.4a02	(SPECIFY 2):	<input type="text"/>
4B1.11.4b02	TOTAL # OF (SPECIFY 2)	<input type="text"/> TOTAL # OF (SPECIFY 2)
4B1.11.4c02	c. How often did you feed the [ANIMALS #2] and/or clean the areas where they were kept? Was it.	<input type="radio"/> Never <input type="radio"/> Occasionally <input type="radio"/> Daily
4B1.11.4d2	d. Were you ever involved in slaughtering the [ANIMALS #2]?	<input type="radio"/> Yes <input type="radio"/> No

[Provide Extra Comments](#)



CHECK RESPONSE in Q4A.4 (end year). If this response indicates that respondent was less than 18 years old, repeat this section for the next residence. If respondent was age 18 or older when he/she moved out of this house, Go to Q4C INTRO.

4C1.1
INTRO

Longest Adult
Residence Address

Start

End Year

Now we have some questions about the 3 residences where you lived for the longest periods of time as an adult, (after you became 18 years of age). We will cover these in chronological order according to the history chart we completed earlier. We'll begin with the residence at: where you lived from: to . These questions will be different from those asked earlier about your childhood residences.

4C1.1	What was the approximate number of people who lived in the area where the residence was located?	<input type="radio"/> 999 or less <input type="radio"/> 1,000-9,999 <input type="radio"/> 10,000-99,999 <input type="radio"/> 100,000-499,999 <input type="radio"/> 500,000 or more
-------	--	---

[Provide Extra Comments](#)

<< >>

If 500,000 or more,
Go to 4C1.3

4C1.2	Was this residence a farm where crops were planted or animals were raised?	<input type="radio"/> Yes <input type="radio"/> No
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[Provide Extra Comments](#)

<< >>

4C1.3	Was there a bathroom inside the house?	<input type="radio"/> Yes <input type="radio"/> No
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4C1.4	Did the house have electricity?	<input type="radio"/> Yes <input type="radio"/> No
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4C1.5	Did the house have an area for burning trash outside the home?	<input type="radio"/> Yes <input type="radio"/> No
-------	--	---

4C1.6	What was the primary source of drinking water at this residence? Was it.	<input type="radio"/> City water (from a central, municipal supply) <input type="radio"/> Village well (communal well that served many houses) <input type="radio"/> Private well (well serving your home only) <input type="radio"/> River or canal water <input type="radio"/> Bottled water purchased at a store <input type="radio"/> Other source (SPECIFY: <input type="text"/>)
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4C1.7	Was water stored in a cistern in this home?	<input type="radio"/> Yes <input type="radio"/> No
-------	---	---

[Provide Extra Comments](#)

<< >>

4C1.8	Was it ever necessary to heat this home?	<input type="radio"/> Yes <input type="radio"/> No
-------	--	---

[Provide Extra Comments](#)

If No, Go to 4C1.10

4C1.9	What kind of fuel was usually used to heat this home? Was it.	<input type="radio"/> gas <input type="radio"/> electric <input type="radio"/> kerosene <input type="radio"/> coal <input type="radio"/> wood <input type="radio"/> Other fuel (SPECIFY: <input style="width: 80px;" type="text"/>)
-------	---	---

[Provide Extra Comments](#)

4C1.10	What kind of fuel was usually used to cook? Was it.	<input type="radio"/> gas <input type="radio"/> electric <input type="radio"/> kerosene <input type="radio"/> coal <input type="radio"/> wood <input type="radio"/> Other fuel (SPECIFY: <input style="width: 80px;" type="text"/>) <input type="radio"/> Not applicable (if no cooking was done in residence).
--------	---	--

4C1.11	How often was stir fry food made with oil served in this home? Was it.	<input type="radio"/> ≤ once per month <input type="radio"/> once a week <input type="radio"/> once a day <input type="radio"/> ≥ twice a day
--------	--	--

4C1.12	While you were living in the home, were any renovations done to the inside of the home, including painting and remodeling (that is, removing or adding walls or adding to the home)?	<input type="radio"/> Yes <input type="radio"/> No
--------	--	---

[Provide Extra Comments](#)

If No, Go to instruction box below

4C1.13	While you were living in the home, was any painting ever completed? If yes, how many times was the interior painted while you lived there?	<input type="radio"/> Yes (# of times) <input style="width: 80px;" type="text"/> <input type="radio"/> No
--------	--	--

4C1.14	While you were living in the home, was any remodeling completed that involved removing or adding walls or adding to the home?	<input type="radio"/> Yes <input type="radio"/> No
--------	---	---

[Provide Extra Comments](#)

Repeat this section for the next 2 longest adult residences.

5A.1	Now to conclude, what was your household's total annual income during the last year?	<input type="text"/> <input type="radio"/> TW\$ <input type="radio"/> HK\$ <input type="radio"/> RMB¥
5A.1b	Finally, what was your household's approximate total <u>annual</u> income during the mid1990's?	<input type="text"/> <input type="radio"/> TW\$ <input type="radio"/> HK\$ <input type="radio"/> RMB¥
VI.1	Interviewer's assessment of the reliability of the answers:	<input type="radio"/> 1 Not very reliable <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input checked="" type="radio"/> 5 Very reliable
VI.2	Has the interviewed person felt uncomfortable?	<input type="radio"/> Yes (Please provide comment below. (VI.6)) <input type="radio"/> No
VI.6	Write down any comments you may have on the interview	<input type="text"/>
Completion date	Completion date	<input type="text" value="21"/> (dd) / <input type="text" value="2"/> (mm) / <input type="text" value="2012"/> (yyyy)

[Provide Extra Comments](#)

This concludes our interview. Thank you very much for your time.
Please stop recording by clicking the button on top of this page.
Update CAPI completion status on your tracking log
[Provide Extra Comments](#)