Attachment 1A

OMB #: 0925-0405
Expiration Date: xx/xx/20xx

U.S. Radiologic Technologists Study
Fourth Survey

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

(ADDRESS BLOCK FOR WINDOW ENVELOPE)

PARTICIPANT NAME
ADDRESS
CITY STATE ZIP

GENERAL INFORMATION

The U.S. Radiologic Technologists Study includes ARRT registrants certified between 1926-1980 in radiology, nuclear medicine, or radiation therapy, regardless of current employment status. Whether you are retired or still working and whether your health has been excellent or if you have been ill, your response is equally important to the study.

We realize it may be hard to recall information from years ago. Just do your best to answer those questions. Even if not exact, your best estimates are valuable to the study.

INSTRUCTIONS:

- USE BLUE OR BLACK INK
- PRINT LEGIBLE NUMBERS AND CAPITAL BLOCK LETTERS IN THE BOXES:

1	2	3		A	B	C	D

- MARK CHECK BOXES: RIGHT ☒ WRONG ☑ ❑

PRIVACY ACT NOTIFICATION STATEMENT
Collection of this information is authorized by The Public Health Service Act, Section 411 (42 USC 285a). Rights of study participants are protected by The Privacy Act of 1974. Please be assured that all information you provide will be kept private under the Privacy Act and will not be disclosed to anyone but the researchers conducting this study, except as otherwise required by law. Any published results from this survey will be reported in statistical summaries only and will never include a participant's name. Your participation in this study is completely voluntary and failure to answer any particular question or the information collection as a whole will not affect your future contacts with the University of Minnesota, the American Registry of Radiologic Technologists, or the National Institutes of Health.

NOTIFICATION TO RESPONDENT OF ESTIMATED BURDEN
Public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. **An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number.** Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0405). Do not return the completed form to this address.

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

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

3. **How tall are you without shoes?** ☐ FEET ☐☐ INCHES

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

5. **Do you currently smoke cigarettes?**
   ❑ No ❑ Yes → **How many cigarettes do you usually smoke per day?** ☐☐ NUMBER PER DAY

   Are you an ex-smoker?
   ❑ No ❑ Yes → **What year did you last smoke cigarettes?** ☐☐☐☐ YEAR LAST SMOKED

6. **Do you have an email address that we can use to contact you in the future to reduce study costs?**
   ❑ No ❑ Yes

   Email address: _____

WORK HISTORY

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

7. Are you currently working as a radiation technologist? ❑ **Yes** ❑ **No** → **Year last worked as a radiation technologist?** Y Y Y Y

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

❑ Unknown ↓

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

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

❑ Estimated
❑ From dosimetry reports
❑ Combination of both

Answer the following questions separately for each time period.

	Before 1945	1945-1964	1965-1979	1980-1989	1990-1999	2000-2009
9. Did you work as a radiation technologist during each time period?	❑ No ❑ Yes	❑ No ❑ Yes	❑ No ❑ Yes	❑ No ❑ Yes	❑ No ❑ Yes	❑ No ❑ Yes
10. How many HOURS PER WEEK did you usually work as a radiation technologist?						

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

❑ No ❑ Yes → **How many TIMES were you removed from working because you exceeded the allowable limit?** ↓

Before 1945	1945-1964	1965-1979	1980-1989	1990-1999	2000-2009

12. Did you ever work as a radiation technologist in a military hospital or clinic, not including VA medical facilities?

❑ No ❑ Yes → **How many YEARS did you work in a military hospital or clinic, not including VA facilities?** ↓

Before 1945	1945-1964	1965-1979	1980-1989	1990-1999	2000-2009

13. How many TIMES, in a typical WEEK, did you perform or assist with the following procedures?

	NEVER DID	NUMBER OF TIMES PER WEEK					
		Before 1945	1945-1964	1965-1979	1980-1989	1990-1999	2000-2009
Diagnostic x-ray	❑						
Routine fluoroscopy	❑						
Fluoroscopically-guided	❑						
Diagnostic radioisotope	❑						
Brachytherapy	❑						
Other therapeutic radioisotope	❑						
External beam radiotherapy	❑						
Ultrasound	❑						

	Before 1945	1945-1964	1965-1979	1980-1989	1990-1999	2000-2009
14. When performing diagnostic x-ray procedures, did you usually have to go into a control booth or shielded area to turn on the x-ray beam?	❑ No ❑ Yes	❑ No ❑ Yes	❑ No ❑ Yes	❑ No ❑ Yes	❑ No ❑ Yes	❑ No ❑ Yes

HEALTH HISTORY

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

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

❑ No (Go to Q16) ❑ Yes

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

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

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

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

❑ No (Go to Q17) ❑ Yes

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

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

If YES:

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

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

_____

HEALTH HISTORY, (continued)

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

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

MEDICAL CONDITION (mark all that apply)	YES	AGE FIRST DIAGNOSED
Benign tumor of brain or nervous system:		
Meningioma	❑	
Schwannoma or neuroma	❑	
Other *(specify)* _____	❑	
Thyroid conditions:	YES	
Thyroid nodule	❑	
Goiter (enlarged thyroid)	❑	
Benign thyroid tumor (adenoma)	❑	
Thyroiditis (Hashimoto's Disease)	❑	
Hypothyroidism (underactive thyroid)	❑	
If YES, did you take medication *(e.g. synthroid, levothyroxine)* for hypothyroidism?	❑ No ❑ Yes	
Grave's Hyperthyroidism or Grave's Disease	❑	
Were you treated *(e.g. surgery, I-131 drugs)* for hyperthyroidism?	❑ No ❑ Yes	
Eye conditions:		
Cataract	❑	
Did you have any cataracts removed?	❑ No ❑ Yes	
Age first removed		AGE
Macular degeneration	❑	
Glaucoma	❑	
Other conditions:	YES	
Sleep apnea	❑	
Osteoporosis	❑	
Hip fracture	❑	
Multiple sclerosis	❑	
Parkinson's Disease	❑	
Lupus	❑	
Osteoarthritis	❑	
Rheumatoid arthritis	❑	
Scleroderma	❑	

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

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

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

PERSONAL DIAGNOSTIC RADIATION EXAMS

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

X-RAY exams performed ON YOU	NEVER HAD	AGE 1ST EXAM	AGE LAST EXAM	NUMBER OF EXAMS BY TIME PERIOD				
				<1965	1965-1979	1980-1989	1990-1999	2000-2009
Dental								
Bite-wing	❑							
Panoramic x-ray	❑							
Skull	❑							
Sinus	❑							
Neck and soft tissue	❑							
Spine								
Full	❑							
Cervical	❑							
Cervical-thoracic	❑							
Thoracic	❑							
Thoracic-lumbar	❑							
Lumbar	❑							
Lumbosacral	❑							
Ribs	❑							
Abdomen	❑							
Pelvis	❑							
Sacrum	❑							
Mammogram	❑							

FLUOROSCOPY exams performed ON YOU with or without X-Rays	NEVER HAD	AGE 1ST EXAM	AGE LAST EXAM	NUMBER OF EXAMS BY TIME PERIOD				
				<1965	1965-1979	1980-1989	1990-1999	2000-2009
Cerebral arteriogram	❑							
Carotid arteriogram	❑							
Cardiac angiogram or catheterization	❑							
Cardiac angioplasty or stent placement	❑							
Pulmonary arteriogram	❑							
Upper GI series	❑							

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FLUOROSCOPY exams performed ON YOU with or without X-Rays, continued	NEVER HAD	AGE 1ST EXAM	AGE LAST EXAM	NUMBER OF EXAMS BY TIME PERIOD <1965	1965-1979	1980-1989	1990-1999	2000-2009
Esophagram (barium swallow)	❑							
Liver, gallbladder, or bile ducts	❑							
Small bowel series	❑							
Lower GI series (barium enema)	❑							

TOMOGRAPHY or CT scans performed ON YOU with or without radionuclides	NEVER HAD	AGE 1ST SCAN	AGE LAST SCAN	NUMBER OF SCANS BY TIME PERIOD <1965	1965-1979	1980-1989	1990-1999	2000-2009
Head	❑							
Neck	❑							
Chest	❑							
Spine	❑							
Abdomen	❑							
CT angiography	❑							

RADIONUCLIDE tests performed ON YOU with or without CT or PET scans	NEVER HAD	AGE 1ST TEST	AGE LAST TEST	NUMBER OF TESTS BY TIME PERIOD <1965	1965-1979	1980-1989	1990-1999	2000-2009
Brain scan	❑							
Thyroid scan	❑							
Thyroid uptake or function	❑							
Cardiac scan	❑							
Lung scan	❑							
Liver scan	❑							
Renogram	❑							
Bone scan	❑							

PERSONAL THERAPEUTIC RADIATION PROCEDURES

20. Please indicate how many times you had the following radionuclide therapy procedures during each time period and provide your age(s) at first and last treatment.

RADIONUCLIDE THERAPY procedures performed ON YOU for the following medical conditions:	NEVER HAD	AGE 1ST TREATED	AGE LAST TREATED	NUMBER OF TREATMENTS BY TIME PERIOD				
				<1965	1965-1979	1980-1989	1990-1999	2000-2009
Hyperthyroidism	❑							
Thyroid cancer or ablation	❑							
Leukemia	❑							
Non-Hodgkin's lymphoma	❑							
Liver tumor	❑							
Bone metastases	❑							
Polycythemia vera	❑							
Cardiac dysfunction	❑							
Colloid (Phosphorus-32)	❑							
Colloid (Gold-198)	❑							

21. Please indicate how many times you had X-Ray therapy to any of the following body areas during each time period for cancer or non-cancer conditions and your age(s) at first and last treatment. If you had a treatment series for a single cancer occurrence, count as one treatment. For non-cancer conditions, count the number of individual treatment sessions that you had.

X-RAY THERAPY procedures performed ON YOU to the following body areas:	NEVER HAD	AGE 1ST TREATED	AGE LAST TREATED	NUMBER OF TREATMENTS BY TIME PERIOD							
				<1980		1980-1989		1990-1999		2000-2009	
				Cancer (series)	Non-cancer (sessions)	Cancer (series)	Non-cancer (sessions)	Cancer (series)	Non-cancer (sessions)	Cancer (series)	Non-cancer (sessions)
Head	❑										
Neck	❑										
Chest (including breast)	❑										
Spine	❑										
Abdomen	❑										

WOMEN ONLY - Men go to Page 9, Question 28)

FEMALE REPRODUCTIVE, GYNECOLOGICAL HISTORY

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

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

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

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

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

❑ No ❑ Yes

Age when first diagnosed? ____ AGE

Age when last diagnosed? ____ AGE

Number of times? ____ NO. TIMES

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

❑ Yes → ____ AGE STOPPED

❑ No, still having periods

❑ No, menstrual periods are irregular or using hormones

❑ Never menstruated

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

❑ No

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

❑ Yes, one or both ovaries removed → ____ FIRST ____ SECOND

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

❑ No ❑ Yes

Age started taking? ____ AGE STARTED

Total number of years taken? ____ YEARS

Currently taking? ❑ No ❑ Yes

BREAST BIOPSY

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

❑ No ❑ Yes

Age at time of first biopsy/aspiration? ____ AGE

Number of biopsies/aspirations? ____ NUMBER

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

WOMEN and MEN complete remainder of Questionnaire.

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

BIRTH AND INFANCY

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

29. Were you breastfed as a baby? ❑ No ❑ Yes

30. Were you born premature? ❑ No ❑ Yes

31. During the year before you were born, were your parents working outside of the home?

FATHER ❑ No ❑ Yes ➔ **What was his job title** (the year before you were born)**?**

MOTHER ❑ No ❑ Yes ➔ **What was her job title** (the year before you were born)**?**

FAMILY MEDICAL HISTORY

32. Have any of your BLOOD-RELATED parents, siblings, or children had any of the following primary cancers? (Mark all that apply)

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

PREVENTIVE HEALTH CARE

33. How many TIMES did you visit a medical facility or clinic for a ROUTINE PREVENTIVE CARE (exam)?

	NUMBER OF EXAMS (at each age)				
	Age 30-39	Age 40-49	Age 50-59	Age 60-69	Age 70 or older
Physical exam	☐☐	☐☐	☐☐	☐☐	☐☐
Sigmoidoscopy or colonoscopy	☐☐	☐☐	☐☐	☐☐	☐☐
Gynecologic exam (women only)	☐☐	☐☐	☐☐	☐☐	☐☐
Breast exam other than during a gynecologic exam (women only)	☐☐	☐☐	☐☐	☐☐	☐☐

PHYSICAL ACTIVITY

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

34. During the PAST YEAR, how many HOURS did you. . .

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

35. During the PAST YEAR, how many HOURS did you . . .

	NUMBER OF HOURS PER DAY							
	NONE	1-2	3-4	5-6	7-8	9-10	11-12	13 hours or more
Sit at work, at home *(e.g. watching TV, at computer)*, or while travelling *(e.g. by car, bus)*	❑	❑	❑	❑	❑	❑	❑	❑

SLEEP PATTERNS, BEDROOM LIGHTING

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

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

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

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

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

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

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

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

❑ No ❑ Yes →

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

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

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

VITAMIN SUPPLEMENT USE

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

	NO	YES	How many DAYS PER WEEK did you take?	
Multivitamins	❑	❑ →	☐☐ →	**What was the brand name of the multivitamin?** ❑ Centrum® ❑ One-A-Day® Essential® ❑ Centrum Silver® ❑ One-A-Day® Women's® ❑ Theragran-M® ❑ Other_____
Calcium (separately or in Tums but not in multivitamins)	❑	❑ →	☐☐ →	**What was the total dosage (mg) of calcium per day?** ❑ Less than 500 mg ❑ 500-899 ❑ 900-1299 ❑ 1300-1599 ❑ 1600 or more
Vitamin D (separately or in calcium but not in multivitamins)	❑	❑ →	☐☐ →	**What was the total dosage (IU) of Vitamin D per day?** ❑ Less than 400 IU ❑ 400-799 ❑ 800-1399 ❑ 1400-1999 ❑ 2000-3999 ❑ 4000 or more

To help us understand skin cancer risk in the USRT study, we have included questions about ultra-violet (UV) radiation exposure.

SUNLAMP AND TANNING BOOTH USE

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

❑ No ❑ Yes →

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

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

❑ No ❑ Yes →

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

SUN EXPOSURE

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

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

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

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

NIGHT SHIFT WORK

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

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

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

WORK HISTORY WITH FLUOROSCOPICALLY-GUIDED OR RADIOISOTOPE PROCEDURES

48. Did you perform or assist with FLUOROSCOPICALLY-GUIDED medical radiation procedures at least once a month for a year or more? ❑ No ❑ Yes → ***Complete Section B - blue***

49. Did you perform or assist with DIAGNOSTIC OR THERAPUTIC RADIOISOTOPE procedures at least once a month for a year or more? ❑ No ❑ Yes → ***Complete Section C - green***