

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

Instructions:

- Use blue or black ink.
- Print legible numbers:

1	2	3
---	---	---
- Mark an X in the box: Right Wrong

<input checked="" type="checkbox"/>	<input type="checkbox"/>
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- Do not make any stray marks on this form. If you have comments, please write them on a separate piece of paper.

GENERAL QUESTIONNAIRE

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

1. What is TODAY'S DATE?

M	M	D	D	2	0	Y	Y
---	---	---	---	---	---	---	---

MONTH DAY YEAR

2. What is your DATE OF BIRTH?

M	M	D	D	1	9	Y	Y
---	---	---	---	---	---	---	---

MONTH DAY 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

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

How many **DAYS** per week do you usually smoke cigarettes?

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 DAYS PER WEEK

Are you an ex-cigarette smoker?

No Yes

What year did you last smoke cigarettes?

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YEAR LAST SMOKED

NOTIFICATION TO RESPONDENT OF ESTIMATED BURDEN

Public reporting burden for this collection of information is estimated to average 30 minutes per response, including 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 (0925-0656). Do not return the completed form to this address.

SERIAL #

HEALTH HISTORY

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

6. Did a doctor ever tell you that you had any type of skin cancer? No (Go to 7) Yes

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

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	<input checked="" type="checkbox"/>	→ <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Squamous cell carcinoma	<input checked="" type="checkbox"/>	→ <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Melanoma.....	<input checked="" type="checkbox"/>	→ <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Other or type unknown.....	<input checked="" type="checkbox"/>	→ <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

7. Did a doctor ever tell you that you had any other type of cancer? No (Go to 8) Yes

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

TYPE OF CANCER (mark all that apply)	YES	AGE FIRST DIAGNOSED	TYPE OF CANCER (mark all that apply)	YES	AGE FIRST DIAGNOSED
Bladder.....	<input checked="" type="checkbox"/>	→ <input type="text"/>	Liver.....	<input checked="" type="checkbox"/>	→ <input type="text"/>
Bone.....	<input checked="" type="checkbox"/>	→ <input type="text"/>	Lung, trachea, or bronchus.....	<input checked="" type="checkbox"/>	→ <input type="text"/>
Brain or nervous system.....	<input checked="" type="checkbox"/>	→ <input type="text"/>	Lymphoma:		
Breast:.....	<input checked="" type="checkbox"/>		Hodgkin's disease.....	<input checked="" type="checkbox"/>	→ <input type="text"/>
			Non-Hodgkin's lymphoma (NHL).....	<input checked="" type="checkbox"/>	→ <input type="text"/>
			Multiple myeloma.....	<input checked="" type="checkbox"/>	→ <input type="text"/>
			Ovary.....	<input checked="" type="checkbox"/>	→ <input type="text"/>
			Pancreas.....	<input checked="" type="checkbox"/>	→ <input type="text"/>
			Prostate.....	<input checked="" type="checkbox"/>	→ <input type="text"/>
			Rectum.....	<input checked="" type="checkbox"/>	→ <input type="text"/>
			Salivary gland.....	<input checked="" type="checkbox"/>	→ <input type="text"/>
			Stomach.....	<input checked="" type="checkbox"/>	→ <input type="text"/>
			Testis.....	<input checked="" type="checkbox"/>	→ <input type="text"/>
			Thyroid.....	<input checked="" type="checkbox"/>	→ <input type="text"/>
			Uterus (endometrium).....	<input checked="" type="checkbox"/>	→ <input type="text"/>
			Other or unknown cancer.....	<input checked="" type="checkbox"/>	→ <input type="text"/>

If YES:

Which breast?		What type was it?			AGE FIRST DIAGNOSED
Left	Right	Invasive Cancer	Ductal Carcinoma In Situ	Other Or Type Unknown	
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	→ <input type="text"/>
<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	→ <input type="text"/>

Specify: _____

8. 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:

Thyroid nodule..... →

Goiter (enlarged thyroid)..... →

Benign thyroid tumor (adenoma)..... →

Thyroiditis (Hashimoto's Disease)..... →

Hypothyroidism (underactive thyroid). →

Did you take medication (e.g., synthroid, levothyroxine) for hypothyroidism? No Yes

Graves' Hyperthyroidism or Graves' Disease..... →

Were you treated (e.g., surgery, I-131 drugs) for hyperthyroidism? No Yes

Eye conditions:

Macular degeneration..... →

Glaucoma..... →

Cataract..... →

Did you have any cataracts removed?..... No Yes

Age first removed..... AGE

Cardiovascular conditions:

Angina pectoris..... →

Was it confirmed by ECG, angiogram, or other diagnostic test?..... No Yes

MEDICAL CONDITION
(mark all that apply) YES AGE FIRST DIAGNOSED

Cardiovascular conditions continued:

Ischemic heart disease..... →

Was it confirmed by ECG, angiogram, or other diagnostic test? No Yes

Heart attack (myocardial infarct)..... →

Stroke..... →

High blood pressure..... →

Do you currently take blood pressure medication? No Yes

Other conditions:

Sleep apnea..... →

Osteoporosis..... →

Hip fracture..... →

Multiple sclerosis..... →

Parkinson's Disease..... →

Lupus..... →

Osteoarthritis..... →

Rheumatoid arthritis..... →

Scleroderma..... →

Chronic bronchitis..... →

Emphysema..... →

Asthma..... →

Diabetes..... →

Do you currently take insulin? No Yes

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

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

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

12. Have any of your blood-related parents, siblings, or children had any of the following primary cancers?

			YOUNGEST age any of these relatives were first diagnosed					
	No	Yes	Under age 40	Ages 40-49	Ages 50-59	Ages 60-69	Age 70 or older	Age Unknown
Brain cancer	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> →	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Breast cancer	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> →	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Thyroid cancer.....	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> →	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Leukemia, lymphoma, or multiple myeloma.....	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> →	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Lung cancer.....	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/> →	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

13. How many TIMES did you visit a medical facility or clinic for a ROUTINE EXAM within each age range?

For example, if you had one exam each year when you were 40-49, report 10 exams for that age range.

	TOTAL NUMBER OF EXAMS WITHIN EACH AGE RANGE				
	Ages 30-39	Ages 40-49	Ages 50-59	Ages 60-69	Age 70 or older
Pap smear (women only)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Breast exam (women only)	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Prostate exam (men only).....	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Sigmoidoscopy or colonoscopy.....	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
General physical exam.....	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

Multivitamins..... No Yes → How many DAYS PER WEEK did you take? DAYS

Other supplements taken separately from a multi-vitamin:

Calcium (including Tums®) No Yes → How many DAYS PER WEEK did you take? DAYS
 What was the total dosage (mg) of calcium per day?
 Less than 500 mg 900-1299 1600 or more
 500-899 1300-1599

Vitamin D (alone or in a calcium supplement) No Yes → How many DAYS PER WEEK did you take? DAYS
 Time of year taken? All year Winter only
 What was the total dosage (IU) of Vitamin D per day?
 Less than 400 IU 800-1399 2000-3999
 400-799 1400-1999 4000 or more

15. Have you ever given birth? No (Go to 17) Yes

For each birth please complete the following questions. Include still births but do not include step- or adopted children.

Birth Order	Year of Birth	Did you breast feed this baby?	How many months?	Birth Order	Year of Birth	Did you breast feed this baby?	How many months?
First	<input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="text"/>	Fifth	<input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="text"/>
Second	<input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="text"/>	Sixth	<input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="text"/>
Third	<input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="text"/>	Seventh	<input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="text"/>
Fourth	<input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="text"/>	Eighth	<input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="text"/>

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

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

No

Yes →

Age when first diagnosed?	<input type="text"/>	AGE	Age when last diagnosed?	<input type="text"/>	AGE	Number of times?	<input type="text"/>	NO. TIMES
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17. Have your menstrual periods stopped permanently (i.e., no period for at least six months)?

No, still having periods

No, menstrual periods are irregular or using hormones

Yes → AGE STOPPED

Never menstruated

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

No Yes, uterus removed → AGE WHEN REMOVED?

Yes, one or both ovaries removed → AGE FIRST OVARY REMOVED AGE SECOND OVARY REMOVED

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

No

Yes →

Age started taking?	<input type="text"/>	AGE STARTED	Total number of years taken?	<input type="text"/>	YEARS	Currently taking?	<input type="checkbox"/> No <input type="checkbox"/> Yes
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20. 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			AGE FIRST DIAGNOSED
	NO	YES		NO	YES	
Breast cancer or ductal carcinoma <i>in situ</i>	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>
Lobular carcinoma <i>in situ</i>	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>
Atypia or atypical hyperplasia	<input type="checkbox"/>	<input type="checkbox"/>	→ <input type="text"/>			

WORK HISTORY

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

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

Y	Y	Y	Y
---	---	---	---

Answer the following questions separately for each time period. If unsure, estimate as best you can.

22. Did you work as a radiologic technologist during these time periods?

	Before 1970	1970-1979	1980-1989	1990-1999	2000-2009
<input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> No
<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> Yes

23. How many HOURS PER WEEK did you usually work as a radiologic technologist during each time period?

	Before 1970	1970-1979	1980-1989	1990-1999	2000-2009										
	<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>		

24. Have you performed or assisted with the following procedures? If YES, please provide the number of procedures within a typical WEEK?

	YES	NUMBER OF PROCEDURES PER WEEK														
		Before 1970	1970-1979	1980-1989	1990-1999	2000-2009										
Diagnostic x-ray.....	<input checked="" type="checkbox"/>	<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>		
Routine fluoroscopy (upper GI series, small bowel series, barium enema, cholecystogram, urethrogram, etc.).....	<input checked="" type="checkbox"/>	<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>		
Intravascular procedures (using catheters) with fluoroscopy in the operating room	<input checked="" type="checkbox"/>	<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>		
Orthopedic and other non-vascular procedures (no catheters) with fluoroscopy in the operating room	<input checked="" type="checkbox"/>	<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>		
Diagnostic radioisotope	<input checked="" type="checkbox"/>	<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>		
Brachytherapy	<input checked="" type="checkbox"/>	<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>		
Other therapeutic radioisotope.....	<input checked="" type="checkbox"/>	<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>			<table border="1" style="width: 40px; height: 20px;"><tr><td> </td><td> </td></tr></table>		

25. Did you perform or assist with FLUOROSCOPICALLY-GUIDED DIAGNOSTIC OR INTERVENTIONAL procedures at least once a month for a year or more?

Include ONLY fluoroscopically-guided interventional procedures (cardiac, cardiac electrophysiology, interventional radiology, endovascular, interventional neurosurgery, and GI/GU endoscopic procedures with fluoroscopic guidance for diagnosis or intervention). Do NOT include routine fluoroscopy exams (such as upper GI series, esophagram, barium enema). → No Yes

26. Did you perform or assist with DIAGNOSTIC OR THERAPEUTIC RADIOISOTOPE procedures at least once a month for a year or more?

No Yes

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

	Before 1960	1960-1969	1970-1979	1980-1989	1990-2009
<input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> No
<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> Yes	<input checked="" type="checkbox"/> Yes

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

No (Go to 29) Yes → How many YEARS did you work in a military facility?

Before 1960	1960-1969	1970-1979	1980-1989	1990-2009
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

No Yes → How many TIMES did this happen?

Before 1960	1960-1969	1970-1979	1980-1989	1990-2009
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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

<input checked="" type="checkbox"/> Zero	<input checked="" type="checkbox"/> 1,000-4,999	<input checked="" type="checkbox"/> 10,000-24,999	<input checked="" type="checkbox"/> 50,000+
<input checked="" type="checkbox"/> 1-999 mrem	<input checked="" type="checkbox"/> 5,000-9,999	<input checked="" type="checkbox"/> 25,000-49,999	<input checked="" type="checkbox"/> Unknown

PERSONAL DIAGNOSTIC RADIATION EXAMS (performed ON YOU)

31. Have you ever had the following personal diagnostic radiation exams? If YES, please provide your age(s) at first and last exam, and the approximate number of exams that you had within each age range. Count the number of exams that you had, NOT the number of films taken.

X-RAY exams performed ON YOU	YES	AGE 1ST EXAM	AGE LAST EXAM	NUMBER OF EXAMS WITHIN EACH AGE RANGE					
				Under Age 30	Ages 30-39	Ages 40-49	Ages 50-59	Ages 60-69	Ages 70-79
Dental, bite-wing.....	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Dental, panoramic x-ray	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Skull.....	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Sinus.....	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Neck	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Spine, full.....	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Spine, cervical	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Spine, thoracic.....	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Spine, lumbar or lumbosacral	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Ribs	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Pelvis or sacrum.....	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mammogram, routine	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Mammogram, diagnostic.....	<input checked="" type="checkbox"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

FLUOROSCOPY exams performed ON YOU <i>with or without</i> X-Ray films	YES	AGE 1ST EXAM	AGE LAST EXAM	NUMBER OF EXAMS WITHIN EACH AGE RANGE						
				Under Age 30	Ages 30-39	Ages 40-49	Ages 50-59	Ages 60-69	Ages 70-79	
Cerebral arteriogram	<input checked="" type="checkbox"/>									
Carotid arteriogram	<input checked="" type="checkbox"/>									
Cardiac angiogram or catheterization	<input checked="" type="checkbox"/>									
Cardiac angioplasty or stent placement	<input checked="" type="checkbox"/>									
Pulmonary arteriogram	<input checked="" type="checkbox"/>									
Upper GI series	<input checked="" type="checkbox"/>									
Esophagram (barium swallow)	<input checked="" type="checkbox"/>									
Liver, gallbladder, or bile ducts	<input checked="" type="checkbox"/>									
Small bowel series	<input checked="" type="checkbox"/>									
Lower GI series (barium enema)	<input checked="" type="checkbox"/>									

TOMOGRAPHY or CT scans performed ON YOU <i>without</i> PET scan. Count scans twice if taken both with and without contrast.	YES	AGE 1ST SCAN	AGE LAST SCAN	NUMBER OF SCANS WITHIN EACH AGE RANGE						
				Under Age 30	Ages 30-39	Ages 40-49	Ages 50-59	Ages 60-69	Ages 70-79	
Head	<input checked="" type="checkbox"/>									
Neck	<input checked="" type="checkbox"/>									
Chest	<input checked="" type="checkbox"/>									
Spine	<input checked="" type="checkbox"/>									
Abdomen with pelvis	<input checked="" type="checkbox"/>									
Abdomen without pelvis	<input checked="" type="checkbox"/>									
CT angiography	<input checked="" type="checkbox"/>									



RADIONUCLIDE tests performed ON YOU <i>without</i> PET scan	YES	AGE 1ST TEST	AGE LAST TEST	NUMBER OF TESTS WITHIN EACH AGE RANGE					
				Under Age 30	Ages 30-39	Ages 40-49	Ages 50-59	Ages 60-69	Ages 70-79
Brain scan	<input checked="" type="checkbox"/>								
Thyroid scan.....	<input checked="" type="checkbox"/>								
Thyroid uptake or function.....	<input checked="" type="checkbox"/>								
Cardiac scan	<input checked="" type="checkbox"/>								
Lung scan.....	<input checked="" type="checkbox"/>								
Liver scan	<input checked="" type="checkbox"/>								
Renogram.....	<input checked="" type="checkbox"/>								
Bone scan	<input checked="" type="checkbox"/>								

PET scans performed ON YOU <i>with or without CT</i>	YES	AGE 1ST SCAN	AGE LAST SCAN	NUMBER OF SCANS WITHIN EACH AGE RANGE					
				Under Age 30	Ages 30-39	Ages 40-49	Ages 50-59	Ages 60-69	Ages 70-79
Brain scan	<input checked="" type="checkbox"/>								
Cardiac scan	<input checked="" type="checkbox"/>								
Whole body scan or tumor localization.....	<input checked="" type="checkbox"/>								
Other.....	<input checked="" type="checkbox"/>								

Specify: _____

PERSONAL THERAPEUTIC RADIATION PROCEDURES

32. Have you ever had radionuclide therapy procedures performed ON YOU for the selected medical conditions below? If YES, please provide your age(s) at first and last treatment, and the approximate number of treatments that you had within each age range.

RADIONUCLIDE THERAPY procedures performed ON YOU for the following medical conditions:	YES	AGE 1ST TREATED	AGE LAST TREATED	NUMBER OF TREATMENTS WITHIN EACH AGE RANGE					
				Under Age 30	Ages 30-39	Ages 40-49	Ages 50-59	Ages 60-69	Ages 70-79
Hyperthyroidism.....	<input checked="" type="checkbox"/>								
Thyroid cancer or ablation.....	<input checked="" type="checkbox"/>								
Leukemia.....	<input checked="" type="checkbox"/>								
Non-Hodgkin's lymphoma	<input checked="" type="checkbox"/>								
Polycythemia vera.....	<input checked="" type="checkbox"/>								
Other.....	<input checked="" type="checkbox"/>								

Specify: _____

33. Have you ever had radiation therapy (radiotherapy, cobalt therapy, etc.) to any of the following body areas for **CANCER** or for **NON-CANCER** conditions? If YES, please provide your age(s) at first and last treatment, and the approximate number of treatments.

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

RADIATION THERAPY procedures performed ON YOU to the following body areas for CANCER conditions:	YES	AGE 1ST TREATED	AGE LAST TREATED	NUMBER OF TREATMENTS WITHIN EACH AGE RANGE CANCER (series)						
				Under Age 30	Ages 30-39	Ages 40-49	Ages 50-59	Ages 60-69	Ages 70-79	
Head.....	<input checked="" type="checkbox"/>									
Neck.....	<input checked="" type="checkbox"/>									
Chest (including breast).....	<input checked="" type="checkbox"/>									
Spine.....	<input checked="" type="checkbox"/>									
Abdomen.....	<input checked="" type="checkbox"/>									

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

RADIATION THERAPY procedures performed ON YOU to the following body areas for NON-CANCER conditions:	YES	AGE 1ST TREATED	AGE LAST TREATED	NUMBER OF TREATMENTS WITHIN EACH AGE RANGE NON-CANCER (sessions)						
				Under Age 30	Ages 30-39	Ages 40-49	Ages 50-59	Ages 60-69	Ages 70-79	
Head.....	<input checked="" type="checkbox"/>									
Neck.....	<input checked="" type="checkbox"/>									
Chest (including breast).....	<input checked="" type="checkbox"/>									
Spine.....	<input checked="" type="checkbox"/>									
Abdomen.....	<input checked="" type="checkbox"/>									

IN YOUR LIFETIME

34. 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?

Under 13 years old 13-19 20-39 40-64 Age 65 or older

How old were you the **LAST** time you used a sunlamp?

Under 13 years old 13-19 20-39 40-64 Age 65 or older

How many times did you use a sunlamp in your life?

1-2 times 3-4 5-9 10-19 20 times or more

35. 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?

Under 13 years old 13-19 20-39 40-64 Age 65 or older

How old were you the **LAST** time you used a tanning booth or tanning bed?

Under 13 years old 13-19 20-39 40-64 Age 65 or older

How many times did you use a tanning booth or tanning bed in your life?

1-2 times 3-4 5-9 10-19 20 times or more

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

Under 13 years old	Ages 13-19	Ages 20-39	Ages 40-64	Age 65 or older
<input type="checkbox"/> Never had a tan	<input type="checkbox"/> Never had a tan	<input type="checkbox"/> Never had a tan	<input type="checkbox"/> Never had a tan	<input type="checkbox"/> Never had a tan
<input type="checkbox"/> 1-3 months	<input type="checkbox"/> 1-3 months	<input type="checkbox"/> 1-3 months	<input type="checkbox"/> 1-3 months	<input type="checkbox"/> 1-3 months
<input type="checkbox"/> 4-6	<input type="checkbox"/> 4-6	<input type="checkbox"/> 4-6	<input type="checkbox"/> 4-6	<input type="checkbox"/> 4-6
<input type="checkbox"/> 7-12 months	<input type="checkbox"/> 7-12 months	<input type="checkbox"/> 7-12 months	<input type="checkbox"/> 7-12 months	<input type="checkbox"/> 7-12 months

37. 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	Ages 13-19	Ages 20-39	Ages 40-64	Age 65 or older
<input type="checkbox"/> Never/rarely	<input type="checkbox"/> Never/rarely	<input type="checkbox"/> Never/rarely	<input type="checkbox"/> Never/rarely	<input type="checkbox"/> Never/rarely
<input type="checkbox"/> Sometimes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Sometimes
<input type="checkbox"/> Usually/always	<input type="checkbox"/> Usually/always	<input type="checkbox"/> Usually/always	<input type="checkbox"/> Usually/always	<input type="checkbox"/> Usually/always

When answering the next two questions about “night shift” work, please include ALL 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.

38. 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?

	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?					
	1	2-3	4-5	6-7	8 or more	1-3	4-5	6-9	10-14	15-19	20 or more
Under age 30 <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Age 30-39 <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Age 40-49 <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Age 50 or older <input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

39. Did you ever work ROTATING night shifts at this age?

Under age 30	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Age 30-39	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Age 40-49	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Age 50 or older	<input type="checkbox"/> No	<input type="checkbox"/> Yes

IN THE PAST YEAR

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

40. During the PAST YEAR, how many HOURS per week did you do the following. . .

	NUMBER OF HOURS PER WEEK						
	NONE	1/2 hr	1 hr	1½	2-3	4-6	7-10

Walk for exercise

(Do not include walking for daily activities, such as shopping).....

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Moderate exercise

(e.g., golf, bowling, softball, yoga, pilates, tai chi)

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Strenuous exercise

(e.g., jogging, vigorous bicycling, swimming, soccer, aerobics).....

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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Weight training or resistance exercises

(e.g., weight machines, free weights).....

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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