

Multi-site Study Adult Questionnaire

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Parent Study ID No. | _____ | (alias, if applicable)

Adult Study ID No. | _____ |

Section A: Demographic Information

A1. What is your age in years?

___ years

___ Refused to answer

A2. What is your sex:

___ Male

___ Female

___ Refused to answer

A3. Do you consider yourself to be Hispanic or Latino?

___ Yes

___ No

___ Refused to answer

A4. What race do you consider yourself to be? Mark all that apply.

___ American Indian or Alaska Native

- Asian
- Black or African American
- Native Hawaiian or Other Pacific Islander
- White
- Refused to answer

A5. What is the highest level of education you completed?

- Less than high school
- Some high school
- High school graduate or equivalent (GED)
- Some university/college
- Technical or trade school
- University/college graduate
- Graduate school or higher

A6. What is your household income (from all sources)?

- Less than \$25,000
- \$25,000 to \$69,000
- \$70,000 to \$149,000
- More than \$150,000
- Don't know
- Refused to answer

A7. During the last 12 months did you have any kind of health insurance?

- Yes
- No
- Don't know
- Refused

Section B: Residential History and Drinking Water Exposures

B1. What is the main source of tap water in your home?

- Public water system
- Private well
- Other: specify _____
- Don't know
- Refused to answer

B2. On average, how many 8 oz. cups of tap water or beverages prepared with tap water do you currently drink per day at home?

- cups
- Don't drink tap water
- Don't know
- Refused to answer

Note: 1 cup = 8 oz.; 2 cups = 1 pint (16 oz.); 4 cups = 1 quart (32 oz.); 16 cups = 1 Gallon (128 oz.)

B3. What was your previous address?

Street _____ Apt _____
City _____ State __ __ Zip Code: _____

B4. When did you move into your previous address? Month____ Year_____

B5. What was the main source of tap water at that address?

- Public water system
- Private well
- Other: specify _____
- Don't know
- Refused to answer

B6. On average, how many 8 oz. cups of tap water or beverages prepared with tap water did you drink per day when you lived at that address?

- cups
- Don't drink tap water
- Don't know
- Refused to answer

Note: 1 cup = 8 oz.; 2 cups = 1 pint (16 oz.); 4 cups = 1 quart (32 oz.); 16 cups = 1 Gallon (128 oz.)

B7. Have you lived at any other address since January 2000?

- Yes
- No → go to Section C
- Don't know → go to Section C
- Refused to answer → go to Section C

B8. Please fill out the table below for these other residences where you lived since January 2000.

Street Address, City, State	Move in	Average	Main source of tap water
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	(mm/yy)	consumption of tap water per day (# cups)	at this address (public water system or private well?)

Section C: History of Potential Exposure Modifiers

C1. Have you ever had a blood transfusion?

Yes → Please specify how many times you had a blood transfusion _____

No → go to Question C3

Don't know → go to Question C3

Refused to answer → go to Question C3

C2. When did you last have a blood transfusion?

_____ month/year

C3. Have you ever donated blood?

Yes → Please specify how many times you have donated blood _____

No → go to Question D1

Don't know → go to Question D1

Refused to answer → go to Question D1

C4. When did you last donate blood?

_____ Month/Year

C5. On average, how often do you donate blood in a year?

Section D: Occupational History

D1. What is your primary occupation?

D2. On average, how many 8 oz. cups of tap water or beverages prepared with tap water do you currently drink per day at work?

___ cups

___ Don't drink tap water

___ Don't know

___ Refused to answer

Note: 1 cup = 8 oz.; 2 cups = 1 pint (16 oz.); 4 cups = 1 quart (32 oz.); 16 cups = 1 Gallon (128 oz.)

D3. Please fill out the table below for each job that lasted one month or more starting from the present and working back to 2000.

Job information	Job 1	Job 2	Job 3	Job 4
a. Where did you work (City, State)				
b. Name of the employer				
c. Start date (month, year)				
d. End date (month, year)				
e. Job title/description				
f. Did you work as a firefighter? If you worked as a firefighter, did you come into contact with firefighting foam used for fires that involve flammable liquids (also known as Class B fires)?	Yes___ No___ go to question g. Yes___ No___ Don't know___	Yes___ No___ go to question g. Yes___ No___ Don't know___	Yes___ No___ go to question g. Yes___ No___ Don't know___	Yes___ No___ go to question g. Yes___ No___ Don't know___
g. Was this job in any of the following industries?	Manufacturing of nonstick cookware ___yes ___no Manufacturing of stain resistant coatings used on carpets, upholstery, and other fabrics ___yes ___no Manufacturing of water resistant clothing ___yes ___no	Manufacturing of nonstick cookware ___yes ___no Manufacturing of stain resistant coatings used on carpets, upholstery, and other fabrics ___yes ___no Manufacturing of water resistant clothing ___yes ___no	Manufacturing of nonstick cookware ___yes ___no Manufacturing of stain resistant coatings used on carpets, upholstery, and other fabrics ___yes ___no Manufacturing of water resistant clothing ___yes ___no	Manufacturing of nonstick cookware ___yes ___no Manufacturing of stain resistant coatings used on carpets, upholstery, and other fabrics ___yes ___no Manufacturing of water resistant clothing ___yes ___no
h. Did you work with or around any chemicals at this job such as solvents, metals, asbestos, or pesticides?	Yes (Please specify the chemical) _____ No ___ Don't know___	Yes (Please specify the chemical) _____ No___ Don't know___	Yes (Please specify the chemical) _____ No___ Don't know___	Yes (Please specify the chemical) _____ No___ Don't know___
i. Did you work with radiation?	Yes___	Yes___	Yes___	Yes___

	No____	No____	No____	No____
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Job information	Job 5	Job 6	Job 7	Job 8
a. Where did you work (City, State)				
b. Name of the employer				
c. Start date (month, year)				
d. End date (month, year)				
e. Job title/description				
f. Did you work as a firefighter? If you worked as a firefighter, did you come into contact with firefighting foam used for fires that involve flammable liquids (also known as Class B fires)?	Yes___ No___ go to question g. Yes___ No___ Don't know___	Yes___ No___ go to question g. Yes___ No___ Don't know___	Yes___ No___ go to question g. Yes___ No___ Don't know___	Yes___ No___ go to question g. Yes___ No___ Don't know___
g. Was this job in any of the following industries?	Manufacturing of nonstick cookware ___yes ___no Manufacturing of stain resistant coatings used on carpets, upholstery, and other fabrics ___yes ___no Manufacturing of water resistant clothing ___yes ___no	Manufacturing of nonstick cookware ___yes ___no Manufacturing of stain resistant coatings used on carpets, upholstery, and other fabrics ___yes ___no Manufacturing of water resistant clothing ___yes ___no	Manufacturing of nonstick cookware ___yes ___no Manufacturing of stain resistant coatings used on carpets, upholstery, and other fabrics ___yes ___no Manufacturing of water resistant clothing ___yes ___no	Manufacturing of nonstick cookware ___yes ___no Manufacturing of stain resistant coatings used on carpets, upholstery, and other fabrics ___yes ___no Manufacturing of water resistant clothing ___yes ___no
h. Did you work with or around any chemicals at this job such as solvents, metals, asbestos, or pesticides?	Yes (Please specify the chemical) _____ No ___ Don't know___	Yes (Please specify the chemical) _____ No___ Don't know___	Yes (Please specify the chemical) _____ No___ Don't know___	Yes (Please specify the chemical) _____ No___ Don't know___
i. Did you work with radiation?	Yes___	Yes___	Yes___	Yes___

	No____	No____	No____	No____
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Job information	Job 9	Job 10	Job 11	Job 12
a. Where did you work (City, State)				
b. Name of the employer				
c. Start date (month, year)				
d. End date (month, year)				
e. Job title/description				
f. Did you work as a firefighter? If you worked as a firefighter, did you come into contact with firefighting foam used for fires that involve flammable liquids (also known as Class B fires)?	Yes___ No___ go to question g. Yes___ No___ Don't know___	Yes___ No___ go to question g. Yes___ No___ Don't know___	Yes___ No___ go to question g. Yes___ No___ Don't know___	Yes___ No___ go to question g. Yes___ No___ Don't know___
g. Was this job in any of the following industries?	Manufacturing of nonstick cookware ___yes ___no Manufacturing of stain resistant coatings used on carpets, upholstery, and other fabrics ___yes ___no Manufacturing of water resistant clothing ___yes ___no	Manufacturing of nonstick cookware ___yes ___no Manufacturing of stain resistant coatings used on carpets, upholstery, and other fabrics ___yes ___no Manufacturing of water resistant clothing ___yes ___no	Manufacturing of nonstick cookware ___yes ___no Manufacturing of stain resistant coatings used on carpets, upholstery, and other fabrics ___yes ___no Manufacturing of water resistant clothing ___yes ___no	Manufacturing of nonstick cookware ___yes ___no Manufacturing of stain resistant coatings used on carpets, upholstery, and other fabrics ___yes ___no Manufacturing of water resistant clothing ___yes ___no
h. Did you work with or around any chemicals at this job such as solvents, metals, asbestos, or pesticides?	Yes (Please specify the chemical) _____ No ___ Don't know___	Yes (Please specify the chemical) _____ No___ Don't know___	Yes (Please specify the chemical) _____ No___ Don't know___	Yes (Please specify the chemical) _____ No___ Don't know___
i. Did you work with radiation?	Yes___ No___	Yes___ No___	Yes___ No___	Yes___ No___

Section E: Medical History

E1. Have you ever been told by a doctor or other health care provider that you have or had any of the following medical conditions? If yes, we may request access to your medical records. Fill out the table below. Circle appropriate response and ask the respondent to specify as directed.

Medical condition		If yes, what year were you diagnosed?
a. Thyroid disease?	Yes (Please specify) _____ No Don't know	__ __ year
b. High cholesterol?	Yes No Don't know	__ __ year
c. High blood pressure? (not including pregnancy induced hypertension)	Yes No Don't know	__ __ year
d. Heart Disease?	Yes No Don't know	__ __ year
e. Osteoarthritis?	Yes No Don't know	__ __ year
f. Osteoporosis	Yes No Don't know	__ __ year
g. Endometriosis?	Yes No Don't know	__ __ year
h. Liver disease?	Yes (Please specify) _____ No Don't know	__ year
i. Kidney disease?	Yes (Please specify) _____ No Don't know	__ year
j. Ulcerative colitis?	Yes No Don't know	__ __ year
k. Rheumatoid arthritis?	Yes No Don't know	__ __ year
l. Lupus?	Yes No Don't know	__ __ year
m. Multiple sclerosis?	Yes No Don't know	__ __ year
n. Diabetes (not related to pregnancy)	Yes (Please specify) _____ No Don't know	__ year
o. Asthma	Yes No Don't know	__ __ year

Medical condition		If yes, what year were you diagnosed?
p. Parkinson Disease	Yes No Don't know	__ __ year
q. Chronic bronchitis	Yes No Don't know	__ __ year
r. Emphysema	Yes No Don't know	__ __ year
s. Fibromyalgia	Yes No Don't know	__ __ year
t. Celiac Disease	Yes No Don't know	__ __ year
u. Crohn's Disease	Yes No Don't know	__ __ year
v. Scleroderma?	Yes No Don't know	__ __ year
w. Atopic dermatitis/eczema?	Yes (Please specify) _____ No Don't know	__ year
x. Allergies?	Yes (Please specify) _____ No Don't know	__ year
y. Infertility?	Yes No Don't know	__ __ year

E2. Have you ever been told by a doctor or other health care provider that you have or had a cancer?

___ Yes, please specify the cancer _____

___ No → go to Question F1 if male; go to Question E7 if female

___ Don't know → go to Question F1 if male; go to Question E7 if female

E3. In what state were you diagnosed with the cancer and when were you diagnosed?

_____ State where you were diagnosed

_____ Year you were diagnosed

E4. Have you been diagnosed with another cancer?

___ Yes, please specify the cancer _____

___ No → go to Question F1 if male; go to Question E7 if female

E5. In what state were you diagnosed with the other cancer and when were you diagnosed?

_____ State where you were diagnosed

_____ Year you were diagnosed

E6. Please list any additional cancer that you were diagnosed with, the year that you were diagnosed, and the state where you were diagnosed:

_____ Type of cancer

_____ Type of cancer

_____ Year diagnosed

_____ Year diagnosed

_____ State where you were diagnosed

_____ State where you were diagnosed

FOR WOMEN ONLY

E7. Have you ever used an oral contraceptive ("birth control pill")?

Yes

No → go to Question E9

Don't know → go to Question E9

Refused to answer → go to Question E9

E8. When did you last use an oral contraceptive ("birth control pill")?

_____ Month/Year

E9. At what age did you begin menstruation (have your first period)?

Age when you began menstruation

Never menstruated → go to Section F

Don't know

E10. Does your period occur regularly (every month)?

Yes → go to Question E13

No, it is irregular → go to Question E13

No, I don't have a period

Don't know → go to Question E13

E11. Why did your periods stop?

Pregnant

Menopausal

Had hysterectomy

Don't know

E12. What age was your last period?

_____ years

Don't know

E12a. During the period when you had periods, what was your usual period flow?

Light → go to Question 16

- Medium → go to Question 16
- Heavy → go to Question 16
- Don't know → go to Question 16

E13. When was your last period before this study blood draw?

- Date: _____
- Don't know

E14. How many days has been your cycle on average during the last year?

- >26 days
- 27-29 days
- 30-32
- >32 days
- Don't know

E15. Can you characterize your usual period flow during the last year?

- Light
- Medium
- Heavy
- Don't know

E16. Have you ever been pregnant?

- Yes
- No → go to Section F
- Don't know

E17. How many times have you been pregnant in your life?

_____ times

E18. Now I'd like to get more information about each of your pregnancies. Let's start with your most recent pregnancy. Fill out the table below. Circle appropriate response and ask the respondent to specify as directed.

	Pregnancy 1	Pregnancy 2	Pregnancy 3	Pregnancy 4
a. What month and year did this pregnancy start?	__ / ____	__ / ____	__ / ____	__ / ____
b. What month and year did this pregnancy end?	__ / ____	__ / ____	__ / ____	__ / ____
c. Did the pregnancy result in a live birth?	Yes No (go to g) Don't Know	Yes No (go to g) Don't Know	Yes No (go to g) Don't Know	Yes No (go to g) Don't Know
d. Did you breastfed this child/these children?	Yes No → go to k. Don't know	Yes No → go to k. Don't know	Yes No → go to k. Don't know	Yes No → go to k. Don't know
e. How long did you	__ months	__ months	__ months	__ months

breastfeed [this child/these children]?				
f. When did you stop breastfeeding this child/these children?	__month __year	__month __year	__month __year	__month __year
g. Did a doctor or nurse say that you had pre-eclampsia during your pregnancy?	Yes No Don't know	Yes No Don't know	Yes No Don't know	Yes No Don't know
h. Did a doctor or nurse say that you had pregnancy-induced hypertension?	Yes No Don't know	Yes No Don't know	Yes No Don't know	Yes No Don't know
i. Did a doctor or nurse say that you had gestational diabetes?	Yes No Don't know	Yes No Don't know	Yes No Don't know	Yes No Don't know

Section F: Social History

The following questions ask about smoking and alcohol use.

F1. Have you ever smoked cigarettes?

Yes

No → go to Question F7

F2. Do you currently smoke cigarettes?

Yes

No → go to Question F5

F3. On average, how many cigarettes do you smoke a day? 1 pack = 20 cigarettes. Enter '00' if less than 1 cigarette per day.

_____ cigarettes per day

F4. In total, how many years have you smoked, excluding any times you may have quit? Enter '00' if less than 1 year.

_____ years → go to Question F7

F5. How many years did you smoke before you quit?

years

Don't know

F5a. How long ago did you quit?

- Less than 5 years ago
- 5-9 years ago
- More than 10 years ago
- Don't know

F6. On average, when you were smoking, about how many cigarettes per day did you smoke? 1 pack = 20 cigarettes. Enter '00' if less than 1 cigarette per day.

_____ cigarettes per day

F7. Have you ever used any other tobacco products (such as chewing tobacco, smokeless tobacco, cigars, a pipe, etc.)?

- Yes
- No → go to Question F10

F8. Do you currently use any of these tobacco products?

- Yes
- No

F9. Have you ever drunk alcoholic beverages? (This includes beer, wine, wine coolers, hard lemonade, and spirits.)

- Yes
- No → go to Section G

F10. Do you currently drink alcoholic beverages? (This includes beer, wine, wine coolers, hard lemonade, and spirits.)

- Yes
- No → go to Section G.

F11. On average, how often do you drink alcoholic beverages?

- Every day or almost every day
- 2 to 4 times a week
- 1 time a week
- 1 to 3 times a month
- Less than once a month

F12. When you drink, how many servings of alcohol do you usually have? One "serving" equals any of the following: 1 can of beer, 1 glass of wine, 1 can or bottle of wine cooler, or 1 shot of liquor.

_____ servings

F13. In total, how many years have you drank, excluding any times you may have quit? Enter '00' if less than 1 year.

___ years → go to Section G

F14. When you were consuming alcoholic beverages, how often did you drink on average?

___ Every day or almost every day

___ 2 to 4 times a week

___ 1 time a week

___ 1 to 3 times a month

___ Less than once a month

F15. When you drank, how many servings of alcohol did you usually have? One "serving" equals any of the following: 1 can of beer, 1 glass of wine, 1 can or bottle of wine cooler, or 1 shot of liquor.

___ servings

F16. In total, how many years did you drink? Enter '00' if less than 1 year.

___ years

F17. How long ago did you quit?

___ Less than 5 years ago

___ More than 5 years ago

___ Don't know

Section G: Family Medical History

G1. Do any of your blood relatives - children, parents, or siblings - currently have cancer or have they had cancer? We are only asking about family members who are blood relatives: children, parents, and siblings.

___ Yes

___ No → go to Question G4

G2. In all, how many family members (not including yourself) have had (or now have) cancer?

___ number

___ Don't know

G3. Now I'd like to get more information about each of your relatives who had/has cancer. Fill out the table below. Circle appropriate response and ask the respondent to specify as directed. Complete the information for the first relative completely before asking about the next relative. Once information about all blood relatives with cancer has been collected, go to Question G4.

	First relative	Second relative	Third relative	Fourth relative
a. Was this relative a . . .	Child Parent	Child Parent	Child Parent	Child Parent

	Sibling	Sibling	Sibling	Sibling
b. What type of cancer did this relative have	_____	_____	_____	_____
c. Is this relative	Living Deceased	Living Deceased	Living Deceased	Living Deceased
d. What year was your relative diagnosed with cancer?	----- Don't know	----- Don't know	----- Don't know	----- Don't know

G4. Have any of your blood relatives (that is children, parents, or siblings) ever been told by a health professional that they have or had any of the following conditions? Fill out the table below. Circle appropriate response and ask the respondent to specify as directed.

Medical condition		If yes, ask: Which relative had this condition?
a. Thyroid disease?	Yes (Please specify) _____ No Don't know	Child Parent Sibling
b. High cholesterol?	Yes No Don't know	Child Parent Sibling
c. High blood pressure? (not including pregnancy induced hypertension)	Yes No Don't know	Child Parent Sibling
d. Heart Disease?	Yes No Don't know	Child Parent Sibling
e. Osteoarthritis?	Yes No Don't know	Child Parent Sibling
f. Osteoporosis?	Yes No Don't know	Child Parent Sibling
g. Endometriosis?	Yes No Don't know	Child Parent Sibling
h. Liver disease?	Yes (Please specify) _____ No Don't know	Child Parent Sibling
i. Kidney disease?	Yes (Please specify) _____ No Don't know	Child Parent Sibling
j. Ulcerative colitis?	Yes No Don't know	Child Parent Sibling
k. Rheumatoid arthritis?	Yes No Don't know	Child Parent Sibling
l. Lupus?	Yes	Child

	No Don't know	Parent Sibling
m. Multiple sclerosis?	Yes No Don't know	Child Parent Sibling
n. Diabetes (not related to pregnancy)?	Yes (Please specify) _____ No Don't know	Child Parent Sibling
o. Asthma?	Yes No Don't know	Child Parent Sibling
p. Parkinson Disease?	Yes No Don't know	Child Parent Sibling
q. Chronic bronchitis?	Yes No Don't know	Child Parent Sibling
r. Emphysema?	Yes No Don't know	Child Parent Sibling
s. Fibromyalgia?	Yes No Don't know	Child Parent Sibling
t. Celiac Disease?	Yes No Don't know	Child Parent Sibling
u. Crohn's Disease?	Yes No Don't know	Child Parent Sibling
v. Scleroderma?	Yes No Don't know	Child Parent Sibling
w. Atopic dermatitis/eczema?	Yes (Please specify) _____ No Don't know	Child Parent Sibling
x. Allergies?	Yes (Please specify) _____ No Don't know	Child Parent Sibling
y. Infertility?	Yes No Don't know	Child Parent Sibling

CONCLUSION: That completes this survey. I would like to sincerely thank you for your time.