

EDITORIAL NOTE: Because this questionnaire was intended to provide names and addresses of relatives, many of whom would then be contacted directly for physical examinations and more detailed information, there was only minimal effort to identify the parents of relatives who might be half-brothers and -sisters. If the information provided will be the basis for constructing a family tree, the questionnaire will have to be modified in a number of places:

- (1) Several of the pages have, in the upper left-hand corner, "To whose children does this chart refer?" Add instructions that say, (All individuals in this page should share precisely the same birth parents; start a new page of the same color if the mother and/or the father changes.)

This questionnaire is designed to be folded into booklet form. The page numbers will make it clear how to fold the pages appropriately.

Family Number

FAMILY HISTORY QUESTIONNAIRE

For each question, please check or record the appropriate response. If your answer does not fit one of the responses provided, feel free to write in your answer.

STATEMENTS IN ALL CAPITAL LETTERS ARE INSTRUCTIONS TO YOU. SUCH STATEMENTS MAY INSTRUCT YOU TO SKIP CERTAIN QUESTIONS OR THEY MAY ASK YOU TO PROVIDE ADDITIONAL INFORMATION ON SOME FAMILY MEMBERS.

When you are asked to provide information about children, we would like you to include all stillbirths and children who may not have lived past infancy.

Please be as thorough as you can. If you don't know the answer to a question, please write DK in the space provided for the answer. There is space on page 16 for any additional information or other comments you may have.

Public reporting burden for this collection of information is estimated to average 45 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, Room 1200, Bethesda, MD 20892-7974, ATTN: PRA (0925-0194). Do not return the completed form to this address.

1. On what date was this questionnaire completed?

|_____| |_____| |_____|
Month Day Year

2. Please record your full name, mailing address, and telephone numbers.

Last Name First Name Middle Name (Maiden Name)

Number and Street Apt. #

City State Zip

(_____) _____ (_____) _____
Area Code Home Phone Area Code Office Phone

3. When were you born?

|_____| |_____| |_____|
Month Day Year

4. Where were you born?

City County State

OR

Foreign Country Year moved to U.S.A.

5. Are you male or female?

Male.....
Female.....

18. Who else might have more health information about your family?

NAME: _____

ADDRESS: _____

PHONE: (_____) _____
AREA CODE NUMBER

RELATIONSHIP TO YOU: _____

NAME: _____

ADDRESS: _____

PHONE: (_____) _____
AREA CODE NUMBER

RELATIONSHIP TO YOU: _____

 Please use this space to write in any additional information about your family's medical history or any other comments you may have.

PLEASE BRIEFLY REVIEW THE QUESTIONNAIRE TO MAKE SURE YOU HAVE NOT OMITTED ANY INFORMATION.

Thank you again for participating in our study of disease in families. Please return all blank charts with your completed questionnaires and charts.

6a. Do you consider yourself to be:

Hispanic or Latino

Not Hispanic or Latino

6b. What is your race?

American Indian or Alaska Native

Asian

Black or African American

Native Hawaiian or Other Pacific

Islander

White

7. What is your national origin or ancestry? (CHECK NO MORE THAN 4.)

England

Ireland

Germany

France

Italy

Greece

Eastern Europe (e.g., Poland,

Russia, Hungary,

Czechoslovakia)

Scandinavia (e.g., Norway,

Sweden, Denmark, Finland)

Spain, Portugal

Other European Countries

Africa

Middle East

India, Pakistan

China

Japan

Other Asian countries or

Pacific Islands

Native American

Canada

Mexico

Puerto Rico

Central America

South America

Other (Specify)

8. Were you raised by someone other than your parents?

No

Yes: _____

Name

Relationship

Name

Relationship

9. Are you a twin or one of a multiple birth?

No..... GO TO Q.10
 Yes COMPLETE Q.9a-c

9a. How many other infants were born with you?

NUMBER

9b. Of those born with you, how many are of an identical relation with you?

NUMBER

9c. Of those born with you, how many are of a fraternal (non-identical) relation with you?

NUMBER

10. In what religion were you raised? Please note that this religion may differ from the religion that you practice as an adult.

None.....
 Catholic.....
 Jewish.....
 Greek Orthodox
 Mormon
 Seventh Day Adventist.....
 Christian Scientist
 Protestant
 If Protestant, what denomination?

 Other
 If Other, please specify

CHART

Did this person ever have cancer, a tumor, or a growth?	Date, place of death, cause of death (If person is deceased.)	Hospital where died (If person is deceased.)	How many children did this person have?
Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> _____ Type or site Year _____ Hospital where diagnosed _____ City State	_____ Month Day Year _____ City _____ County State _____ Cause	_____ Name of Hospital _____ City _____ County State _____ Physician (if known)	_____ Number
Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> _____ Type or site Year _____ Hospital where diagnosed _____ City State	_____ Month Day Year _____ City _____ County State _____ Cause	_____ Name of Hospital _____ City _____ County State _____ Physician (if known)	_____ Number
Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> _____ Type or site Year _____ Hospital where diagnosed _____ City State	_____ Month Day Year _____ City _____ County State _____ Cause	_____ Name of Hospital _____ City _____ County State _____ Physician (if known)	_____ Number
Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> _____ Type or site Year _____ Hospital where diagnosed _____ City State	_____ Month Day Year _____ City _____ County State _____ Cause	_____ Name of Hospital _____ City _____ County State _____ Physician (if known)	_____ Number

PLEASE COMPLETE THIS CHART FOR ANY RELATIVE WITH CANCER FOR WHOM YOU HAVE NOT FILLED OUT INFORMATION IN EARLIER SECTIONS OF THIS QUESTIONNAIRE.

ADDITIONAL RELATIVES'

Relationship to you	Name, date of birth and, if living, address and phone number
Relationship _____	Last _____ First _____ Middle _____ (Maiden _____)
Mother _____	Street Address _____
Father _____	City _____ State _____ Zip _____
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Phone: (_____) _____ Area Code Number
	Date of Birth: MO _____ DAY _____ YR _____
Relationship _____	Last _____ First _____ Middle _____ (Maiden _____)
Mother _____	Street Address _____
Father _____	City _____ State _____ Zip _____
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Phone: (_____) _____ Area Code Number
	Date of Birth: MO _____ DAY _____ YR _____
Relationship _____	Last _____ First _____ Middle _____ (Maiden _____)
Mother _____	Street Address _____
Father _____	City _____ State _____ Zip _____
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Phone: (_____) _____ Area Code Number
	Date of Birth: MO _____ DAY _____ YR _____
Relationship _____	Last _____ First _____ Middle _____ (Maiden _____)
Mother _____	Street Address _____
Father _____	City _____ State _____ Zip _____
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Phone: (_____) _____ Area Code Number
	Date of Birth: MO _____ DAY _____ YR _____

11. What is the name, office address, and office phone number of your regular doctor?

Last Name First Middle

Street Address Apt. #

City State Zip

(_____) _____
Area Code Office Phone

12. Did a physician ever state that you had cancer?

No GO TO Q.13

Yes COMPLETE Q.12a-d

12a. What type of cancer did the physician state you had? Where did it begin in your body?

Type Place it Began

12b. When did the physician diagnose this cancer?

Year

12c. What is the name and office address of the physician who diagnosed this cancer?

Last Name First Middle

Street Address Apt. #

City State Zip

12d. What is the name and address of the hospital or health care facility where the diagnosis was made?

_____ Hospital/Clinic Name
 _____ Street Address
 _____ City _____ State _____ Zip

13. What is your marital status?

Married or living as married.....
 Widowed.....
 Separated.....
 Never married.....
 Divorced.....
 Remarried.....

IF YOU HAVE EVER BEEN MARRIED, ANSWER Q.14 THROUGH Q.17.
 IF YOU PARENTED CHILDREN WITH A PERSON TO WHOM YOU WERE NOT MARRIED, CONSIDER THAT PERSON AS A SPOUSE.

14. What is the full name and birthdate of your current or most recent spouse?

_____ Last Name _____ First Name _____ Middle Name _____ (Maiden Name)
 Date of Birth _____
 Month Day Year

CHART

Did this person ever have cancer, a tumor, or a growth?	Date, place of death, cause of death (If person is deceased.)	Hospital where died (If person is deceased.)	How many children did this person have?
Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> _____ Type or site Year _____ Hospital where diagnosed City State	_____ _____ _____ Month Day Year _____ City _____ County State _____ Cause	_____ Name of Hospital _____ City _____ County State _____ Physician (if known)	_____ Number
Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> _____ Type or site Year _____ Hospital where diagnosed City State	_____ _____ _____ Month Day Year _____ City _____ County State _____ Cause	_____ Name of Hospital _____ City _____ County State _____ Physician (if known)	_____ Number
Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> _____ Type or site Year _____ Hospital where diagnosed City State	_____ _____ _____ Month Day Year _____ City _____ County State _____ Cause	_____ Name of Hospital _____ City _____ County State _____ Physician (if known)	_____ Number
Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> _____ Type or site Year _____ Hospital where diagnosed City State	_____ _____ _____ Month Day Year _____ City _____ County State _____ Cause	_____ Name of Hospital _____ City _____ County State _____ Physician (if known)	_____ Number

IF YOU HAVE ADDITIONAL RELATIVES WITH CANCER, GO TO NEXT PAGE.

PLEASE COMPLETE THIS CHART FOR ANY RELATIVE WITH CANCER FOR WHOM YOU HAVE NOT FILLED OUT INFORMATION IN EARLIER SECTIONS OF THIS QUESTIONNAIRE.

ADDITIONAL RELATIVES'

Relationship to you	Name, date of birth and, if living, address and phone number
Relationship _____	Last _____ First _____ Middle _____ (Maiden _____)
Mother _____	Street Address _____
Father _____	City _____ State _____ Zip _____
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Phone: (_____) _____ Area Code Number
	Date of Birth: MO _____ DAY _____ YR _____
Relationship _____	Last _____ First _____ Middle _____ (Maiden _____)
Mother _____	Street Address _____
Father _____	City _____ State _____ Zip _____
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Phone: (_____) _____ Area Code Number
	Date of Birth: MO _____ DAY _____ YR _____
Relationship _____	Last _____ First _____ Middle _____ (Maiden _____)
Mother _____	Street Address _____
Father _____	City _____ State _____ Zip _____
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Phone: (_____) _____ Area Code Number
	Date of Birth: MO _____ DAY _____ YR _____
Relationship _____	Last _____ First _____ Middle _____ (Maiden _____)
Mother _____	Street Address _____
Father _____	City _____ State _____ Zip _____
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Phone: (_____) _____ Area Code Number
	Date of Birth: MO _____ DAY _____ YR _____

15. With this spouse, did you parent any children, including stillbirths and children who may not have lived past infancy?

Yes
No

IF THE ANSWER TO Q.15 IS "YES," FILL OUT A GREEN CHART FOR CHILDREN. INSTRUCTIONS FOR FILLING OUT THE CHARTS IN THIS QUESTIONNAIRE APPEAR ON THE YELLOW CHART.

IF YOU HAVE BEEN MARRIED MORE THAN ONCE, ANSWER Q.16 AND Q.17. IF YOU PARENTED CHILDREN WITH A PERSON TO WHOM YOU WERE NOT MARRIED, CONSIDER THAT PERSON AS A SPOUSE.

IF YOU HAVE NEVER HAD A CHILD, TURN THE PAGE AND COMPLETE THE CHART ON YOUR PARENTS.

16. What is the full name and birthdate of your first spouse?

_____ Last Name _____ First Name _____ Middle Name _____ (Maiden Name)

Date of Birth |_____| |_____| |_____|
Month Day Year

17. Did you parent any children with this spouse?

Yes
No

IF THE ANSWER TO Q.17 IS "YES," FILL OUT A SEPARATE GREEN CHART FOR CHILDREN BY THIS FIRST SPOUSE.

IF YOU HAVE BEEN MARRIED MORE THAN TWICE, PLEASE LIST THE NAMES OF YOUR ADDITIONAL SPOUSES AND FILL IN SEPARATE GREEN CHARTS FOR CHILDREN BY ANY ADDITIONAL SPOUSES.

WHEN YOU HAVE COMPLETED ALL CHARTS FOR YOUR CHILDREN, PLEASE TURN TO PAGES 6 AND 7 AND FILL IN THE CHART ON YOUR PARENTS.

PARENTS'

Relationship to you	Name, date of birth and, if living, address and phone number
Mother <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____ (_____) Last First Middle Maiden _____ Street Address _____ City State Zip Phone: (_____) Area Code Number Date of Birth: MO _____ DAY _____ YR _____
	_____ Last First Middle _____ Street Address _____ City State Zip Phone: (_____) Area Code Number Date of Birth: MO _____ DAY _____ YR _____

CHART

Did this person ever have cancer, a tumor, or a growth?	Date, place of death, cause of death (If person is deceased.)	Hospital where died (If person is deceased.)	How many children did this person have?
Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> _____ Type or site Year _____ Hospital where diagnosed City State _____ Cause	_____ Month Day Year _____ City _____ County State _____ Cause	_____ Name of Hospital _____ City _____ County State _____ Physician (if known)	_____ Number
Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> _____ Type or site Year _____ Hospital where diagnosed City State _____ Cause	_____ Month Day Year _____ City _____ County State _____ Cause	_____ Name of Hospital _____ City _____ County State _____ Physician (if known)	_____ Number
Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/> _____ Type or site Year _____ Hospital where diagnosed City State _____ Cause	_____ Month Day Year _____ City _____ County State _____ Cause	_____ Name of Hospital _____ City _____ County State _____ Physician (if known)	_____ Number

To whose children does this chart refer?

SISTERS' AND BROTHERS'

CHART

_____ | _____
Mother's Name | **Father's Name**

LIST IN ORDER OF BIRTH

Relationship to you	Name, date of birth and, if living, address and phone number
Sister <input type="checkbox"/>	_____ (_____) _____ Last First Middle Maiden _____ Street Address _____ City State Zip Phone: (_____) _____ Area Code Number Date of Birth: MO _____ DAY _____ YR _____
Brother <input type="checkbox"/>	
Half-Brother (same mother) <input type="checkbox"/>	
Half-Brother (same father) <input type="checkbox"/>	
Half-Sister (same mother) <input type="checkbox"/>	
Half-Sister (same father) <input type="checkbox"/>	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Sister <input type="checkbox"/>	_____ (_____) _____ Last First Middle Maiden _____ Street Address _____ City State Zip Phone: (_____) _____ Area Code Number Date of Birth: MO _____ DAY _____ YR _____
Brother <input type="checkbox"/>	
Half-Brother (same mother) <input type="checkbox"/>	
Half-Brother (same father) <input type="checkbox"/>	
Half-Sister (same mother) <input type="checkbox"/>	
Half-Sister (same father) <input type="checkbox"/>	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	
Sister <input type="checkbox"/>	_____ (_____) _____ Last First Middle Maiden _____ Street Address _____ City State Zip Phone: (_____) _____ Area Code Number Date of Birth: MO _____ DAY _____ YR _____
Brother <input type="checkbox"/>	
Half-Brother (same mother) <input type="checkbox"/>	
Half-Brother (same father) <input type="checkbox"/>	
Half-Sister (same mother) <input type="checkbox"/>	
Half-Sister (same father) <input type="checkbox"/>	
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	

Did this person ever have cancer, a tumor, or a growth?	Date, place of death, cause of death (If person is deceased.)	Hospital where died (If person is deceased.)	How many children did this person have?
Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>	_____ Month Day Year _____ Type or site Year _____ Hospital where diagnosed _____ City State	_____ Name of Hospital _____ City _____ County State _____ Cause _____ Physician (if known)	_____ Number
Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>	_____ Month Day Year _____ Type or site Year _____ Hospital where diagnosed _____ City State	_____ Name of Hospital _____ City _____ County State _____ Cause _____ Physician (if known)	_____ Number
Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>	_____ Month Day Year _____ Type or site Year _____ Hospital where diagnosed _____ City State	_____ Name of Hospital _____ City _____ County State _____ Cause _____ Physician (if known)	_____ Number
Yes <input type="checkbox"/> No <input type="checkbox"/> DK <input type="checkbox"/>	_____ Month Day Year _____ Type or site Year _____ Hospital where diagnosed _____ City State	_____ Name of Hospital _____ City _____ County State _____ Cause _____ Physician (if known)	_____ Number

IF YOU HAVE ADDITIONAL SISTERS AND BROTHERS, FILL OUT THE WHITE SISTERS AND BROTHERS CHART.