Questionnaire

Genomic Analysis of Patients with Pancreatic Cancer

Survey Questionnaire

Section 1

The following questions will help us compare information among men and women of similar characteristics, such as age and education. No one will be identified individually

1. How many people live in your household (count yourself as one)? _____________

2. Please choose the income category that matches your total household income for the last year. This information is used for statistical purposes only.
   - ☐ Less than $15,000
   - ☐ At least $15,000 but less than $25,000
   - ☐ At least $25,000 but less than $35,000
   - ☐ At least $35,000 but less than $50,000
   - ☐ $50,000 or more
   - ☐ Don’t know

3. What is your current marital status?
   - ☐ Single
   - ☐ Married
   - ☐ Not married, but living together
   - ☐ Separated
   - ☐ Divorced
   - ☐ Widowed
   - ☐ Other: _______________

4. What is the highest grade of formal education that you have completed?
   - ☐ None
   - ☐ Elementary school (1-8 years)
   - ☐ Some high school (9-11 years)
   - ☐ High school graduate (12 years)
   - ☐ GED
   - ☐ Some college
   - ☐ College graduate
   - ☐ Some graduate school
   - ☐ Graduate or professional degree
   - ☐ Other: ___________________

5. Do you work?
   - ☐ Yes, full time
   - ☐ Yes, part time
   - ☐ No

6. What is your race?
   - ☐ Caucasian
   - ☐ African American
   - ☐ Asian / Pacific Islander
   - ☐ American Indian / Alaskan native
   - ☐ Eskimo and Aleut
   - ☐ Other: ____________________

7. Are you of Hispanic origin?
   - ☐ Yes
   - ☐ No

8. What is your birth date?

   _______ _______ __________
   month day year

9. Are you:
   - ☐ Female
   - ☐ Male

10. How tall are you without shoes? ___________________________

11. How much do you weigh without shoes? ____________________________

Please answer the following questions to help us better understand your health behaviors.

Section 2

The next questions are about smoking and tobacco use.

1. Have you smoked at least **100** cigarettes on your lifetime?
   - ☐ Yes (GO TO QUESTION #2)
   - ☐ No (GO TO QUESTION #9)

2. How old were you when you **first** started to smoke cigarettes on a regular basis?
   __________ years

3. Do you now smoke cigarettes every day, some days, not at all?
   - ☐ every day (GO TO QUESTION #4)
   - ☐ some days (GO TO QUESTION #4)
   - ☐ not at all (GO TO QUESTION #6)

4. On the average, when you smoked during the PAST 30 DAYS, about how many *cigarettes* did you smoke a day?

   ____

5. Is your usual cigarette brand menthol or non-menthol? (GO TO QUESTION #9)
   - ☐ Menthol
   - ☐ Non-menthol
   - ☐ Don't know/not sure

6. How long has it been since you quit smoking? ________________________

7. How long did you smoke cigarettes before you stopped smoking completely?

   ____

8. Thinking back over the years you used to smoke regularly, about how many *cigarettes* did you usually smoke each day?

   ____

9. Have you ever used any of the following tobacco products even once?
   - ☐ pipe
   - ☐ cigar
   - ☐ snuff, such as Skoal, Bandit or Copenhagen
   - ☐ chewing tobacco, such as Redman, Levi Garrett, or Beechnut
   - ☐ bidis
   - ☐ No, never used any of these tobacco products (GO TO QUESTION #11)

10. Do you now use any of the above tobacco products every day, some days, not at all?
    - ☐ every day
    - ☐ some days
    - ☐ not at all

11. In a usual week, does ANYONE, including yourself, smoke cigarettes, cigars, or pipes anywhere inside your home?
    - ☐ Yes
    - ☐ No

12. During the past 30 days, has anyone smoked in your immediate work area?
    - ☐ Yes
    - ☐ No

Section 3

These next questions are about drinking alcoholic beverages. Included are liquor such as whiskey or gin, beer, wine, wine coolers, and any other type of alcoholic beverage.

1. In your ENTIRE LIFE, have you had at least 12 drinks of any type of alcoholic beverage?
   - ☐ Yes (GO TO QUESTION #2)
   - ☐ No (GO TO NEXT SECTION)

2. In ANY ONE YEAR, have you had at least 12 drinks of any type of alcoholic beverage?
   - ☐ Yes
   - ☐ No

3. In the PAST YEAR, how many days per week, month, or year did you drink any type of alcoholic beverage?
   - ___________________ days per week (GO TO QUESTION #4)
   - ___________________ days per month (GO TO QUESTION #4)
   - ___________________ days per year (GO TO QUESTION #4)
   - ☐ None, I never had any type of alcohol beverage in the past year (GO TO NEXT SECTION)

4. In the PAST YEAR, on those days that you drank alcoholic beverages, on the average, how many drinks did you have?

____

Section 4

These questions are about the different kinds of foods you ate or drank during the PAST MONTH, (past 30 days). When answering, include meals and snacks eaten at home, at work or school, in restaurants, and anyplace else. Please indicate by placing an X in the box of how often you eat/drink the following foods.

	Never	1-3 times a month	1-2 times a week	3-4 times a week	Every day	More than once a day
Soda or soft drinks with sugar						
Diet soda or soft drinks						
Coffee (decaf or regular)						
Tea (hot or iced)						
Orange juice						
Cranberry juice						
Apple juice						
Milk						
Ice Cream						
Fruit (fresh, frozen or canned)						
Salad						
Other vegetables						
Tomato sauce or salsa						
Cereal						
Whole grain bread						
Bread (not whole grain)						
Eggs						
Bacon						
Sausage						
Red meat						
Fish (seafood)						
Fish (freshwater)						
Shellfish						
Chicken						
Deli meats						
Processed meats (*i.e.,* Spam)						
Beef jerky (or other jerky)						
Fried foods						

	Never	1-3 times a month	1-2 times a week	3-4 times a week	Every day	More than once a day
French fries						
Baked potatoes						
Boiled potatoes						
Mashed potatoes						
Rice						
Pasta						
Beans (Pinto, Navy, etc)						
Cookies						
Cake						
Other (Twinkies, etc)						

Section 5

These questions are about vitamins or other supplements you have taken during the PAST 12 MONTHS. Indicate how often you take the product by placing an X in the box.

	Never	1-3 times a month	1-2 times a week	3-4 times a week	Every day	More than once a day	Don't know
Multivitamin (One-a-Day, Theragran, Centrum)							
Vitamin A (BETA CAROTENE)							
Vitamin B or B-12							
Vitamin C							
Vitamin D							
Vitamin E							
Lycopene							
Folic Acid or Folate							
Calcium							
Selenium							
Zinc							
Glucosamine (with or without Chondroitin)							
Echinacea							
Fish Oil							
Garlic pills							
Green tea							
Ginko Biloba							
Melatonin							
Valerian							
Soy products							
Black Cohosh							
DHEA							
Ma Huang or Ephedra							
Saw Palmetto							
Shark Cartilage							
Ginseng							
St John's Wort							
Mistletoe							
Other (Please list):							

Section 6

(Pancreatic Cancer patients only)

People with cancer sometimes use different therapies or treatments. Please indicate by placing an X in the box of how often you have used the following therapies to treat your cancer.

	Never	In the past month	In the past year	More than a year ago
Chelation therapy				
Kelly Diet or Gonzalez therapy				
Antineoplastons or Burzynski therapy				
Gerson therapy				
Detoxification				
Alkalinization therapy				
Livingston therapy				
Hoxsey therapy				
Other (Please list):				

Section 7
Health History

These questions are about your health history. Please indicate whether or not you have the following diseases by placing an X in the appropriate box. Please mark "YES" or "NO" for each disease.

	YES	NO
Diabetes (type 2)		
Diabetes (juvenile type 1)		
Pancreas		
Chronic pancreatitis		
Inflammatory bowel disease (Crohn's, Ulcerative Colitis)		
Lupus		
Rheumatoid arthritis		
Vasculitis		
TB		
Heart disease		
Stroke		
Neurodegenerative disease (Alzheimer's, Parkinson's)		

Section 8
Employment History

Fill in the table below listing all jobs you have worked for periods of one year or more, include military service. Begin with your most recent job. Use additional paper if needed.

Dates of Employment	Job Title & Description of Work	Exposures*	Protective Equipment

*List the chemicals, dusts, fibers, fumes, radiation, biologic agents (*i.e.,* molds or viruses) and physical agents (*i.e.*, extreme heat, cold, vibration, or noise) that you were exposed to at this job.

Section 9
Environmental History

1. Do you live next to or near an industrial plant, commercial business, dump site, or nonresidential property? No Yes

2. Which of the following to you have in your home? *Please circle all that apply.*

Air conditioner	Air purifier	Central gas heating	Gas stove	
Electric stove	Fireplace	Central oil heating	Wood	Humidifier

3. Have you recently acquired new furniture or carpet, fefinished furniture, or remodeled your home? No Yes

4. Have you weatherized your home recently? No Yes

5. Are pesticides or herbicides (bugs or weed killers; flea and tick sprays, collars, powders, or shampoos) used in your home or garden, or on pets? No Yes

6. Do you (or any household member) have a hobby or craft? No Yes

7. Do you work on your car? No Yes

8. Have you ever changed your residence because of a health problem? No Yes

9. Does your drinking water come from:
   - a) private well? No Yes
   - b) city water supply? No Yes
   - c) grocery store? No Yes

10. Approximately how old is your home? ______________________

11. Have you been or are currently exposed to any of the following?
    - Dust or fibers No Yes
    - Chemicals No Yes
    - Fumes No Yes
    - Radiation No Yes
    - Biologic agents No Yes
    - Loud noise, vibration, extreme heat or cold No Yes

12. Have you been exposed to any of the above in the past? No Yes

13. Do any household members have contact with metals, dust, fibers, chemicals, fumes, radiation, or biologic agents? No Yes

14. Do you know the names of the metals, dusts, fibers, chemicals, fumes, or radiation that you are/were exposed to? No Yes
    If yes to question 14, list them below:

15. Do you use protective equipment such as gloves, masks, respirator, or hearing protectors? No Yes
    If yes to question 9, list the protective equipment used:

16. Do you wash your hands with solvents? No Yes

17. Do you eat at the workplace? No Yes

18. Do you know of any co-workers experiencing similar or unusual symptoms? No Yes

19. Has there been a change in the health or behavior of family pets? No Yes

Have you ever worked at a job or hobby in which you came in contact with any of the following by breathing, touching, or ingesting (swallowing)? If *yes*, please check the circle beside the name.

○ Acids	○ Chloroprene	○ Methylene chloride	○ Styrene
○ Alcohols	○ Chromates	○ Nickel	○ Talc
○ Alkalies	○ Coal dust	○ PBBs	○ Toluene
○ Ammonia	○ Dichlorobenzene	○ PCBs	○ TDI or MDI
○ Arsenic	○ Ethylene dibromide	○ Perchloroethylene	○ Trichloroethylene
○ Asbestos	○ Ethylene dichloride	○ Pesticides	○ Trinitrotoluene
○ Benzene	○ Fiberglass	○ Phenol	○ Vinyl chloride
○ Beryllium	○ Halothane	○ Phosgene	○ Welding fumes
○ Cadmium	○ Isocyanates	○ Radiation	○ X-rays
○ Carbon tetrachloride	○ Ketones	○ Rock dust	○ Other (specify)
○ Chlorinated naphthalenes	○ Lead	○ Silica powder	
○ Chloroform	○ Mercury	○ Solvents	