Atlantic PATH

PARTNERSHIP FOR TOMORROW'S HEALTH
For the Benefit of Future Generations

2

Core Questionnaire

The Atlantic Path Research Project

Please return this part to Atlantic Path
in the envelope provided. Thank you.

Canadian Partnership for Tomorrow Project
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Atlantic PATH – PARTNERSHIP FOR TOMORROW'S HEALTH – For the Benefit of Future Generations

DIRECTIONS FOR COMPLETING THIS QUESTIONNAIRE

This questionnaire may take about 35 to 60 minutes to answer. Please follow the directions carefully. You will be asked to **skip** certain questions that do not apply to you.

We appreciate you completing the whole questionnaire. However, if a question is not answered or left blank, it will mean that you prefer not to answer a question.

- Use a ballpoint pen, not a felt pen.
- Shade in the squares completely, like this: ■
- If you make an error, put an **X** through the incorrect box.
- You will need information about your prescription medications. Before starting the questionnaire, it would be useful to have these handy.
- If you are not sure how to answer a question, please feel free to call or email us.

Here's our contact information.
Atlantic Path
Toll Free 1-877-285-7284
Halifax 494-7284
Email us at *info@atlanticpath.ca*

For a list of commonly asked questions (FAQ's), visit our website
www.atlanticpath.ca

DEMOGRAPHIC INFORMATION

DE01 Date of birth: DD _____ MM _____ YYYY _____

DE02 What is your sex?

- ☐ Male
- ☐ Female

FAMILY CHARACTERISTICS

FA01 What is your **current** marital status*? Please choose the **ONE** status that best describes your current situation.*

- ☐ Married and/or living with a partner
- ☐ Divorced
- ☐ Widowed
- ☐ Separated
- ☐ Single, never married

FA02 How many **biological** siblings (brothers and sisters) do you have, including those who have died*? Include half-siblings (one common parent) but not step-siblings or adopted siblings.*

- ____ Number of Brothers
- ____ Number of Sisters
- ☐ Don't know

If "0" BROTHER AND "0" SISTER or "DON'T KNOW", please **skip** to FA05 on page 2

FA03 How many of your biological siblings are, or were, older than you? *If you are part of a multiple birth (e.g., twins, triplets, etc.) please treat all of the siblings that were born with you as being the same age as you, regardless of the order in which you were actually born.*

- ____ Siblings
- ☐ Don't know

FA04 Are you a twin or part of a multiple birth? *Multiple births include twins, triplets, quadruplets, quintuplets, sextuplets, etc.*

- ☐ Yes
- ☐ No
- ☐ Don't know

FA05 Were you adopted?

- ☐ Yes
- ☐ No
- ☐ Don't know

EDUCATION LEVEL

EL01 What is the highest level of education you have completed?

- ☐ Elementary School
- ☐ High School
- ☐ Trade, technical or vocation school, apprenticeship training or technical CEGEP
- ☐ Diploma for a community college, pre-university CEGEP or non-university certificate
- ☐ University certificate below Bachelor's level
- ☐ Bachelor's degree
- ☐ Graduate degree (MSc, MBA, MD, Ph.D, etc.)
- ☐ None ***Skip** to* HS01 HEALTH STATUS *on this page*

EL02 What was your age when you **completed** this level of education?

- ____ Age when you completed this level of education
- ☐ Don't know

HEALTH STATUS

HS01 How would you rate your general health?

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

HS02 When was the **last** time you had a routine medical check-up, undertaken by a doctor or a nurse? *A medical check-up is a physical exam that usually includes at least a blood pressure measurement and height and weight measurement.*

- ☐ Less than 6 months ago
- ☐ 6 months to less than 1 year ago

- ☐ 1 year to less than 2 years ago
- ☐ 2 years to less than 3 years ago
- ☐ 3 or more years ago
- ☐ Never
- ☐ Don't know

HS03 When was the **last** time you saw a dental professional, including dentist or hygienist?

- ☐ Less than 6 months ago
- ☐ 6 months to less than 1 year ago
- ☐ 1 year to less than 2 years ago
- ☐ 2 years to less than 3 years ago
- ☐ 3 or more years ago
- ☐ Never
- ☐ Don't know

HS04 When was the **last** time you had a fecal occult blood test or an FOBT? *A Fecal Occult Blood Test or FOBT is a test to check for blood in your stool, where you have a bowel movement and use a stick or a small brush to smear a small sample on a special card. It is usually collected at home for two or three days in a row.*

- ☐ Less than 6 months ago
- ☐ 6 months to less than 1 year ago
- ☐ 1 year to less than 2 years ago
- ☐ 2 years to less than 3 years ago
- ☐ 3 or more years ago
- ☐ Never
- ☐ Don't know

HS05 When was the **last** time you had a colonoscopy? *A colonoscopy is an exam where a long tube is used to examine the entire colon. Before the procedure is done, you are usually given a sedative.*

- ☐ Less than 6 months ago
- ☐ 6 months to less than 1 year ago
- ☐ 1 year to less than 2 years ago
- ☐ 2 years to less than 3 years ago
- ☐ 3 or more years ago
- ☐ Never
- ☐ Don't know

HS06 When was the **last** time you had a sigmoidoscopy? *A sigmoidoscopy is an exam where a flexible tube is inserted into the rectum and lower part of the large bowel to look for signs of cancer or other problems. The procedure does **not** usually require sedation.*

- ☐ Less than 6 months ago
- ☐ 6 months to less than 1 year ago
- ☐ 1 year to less than 2 years ago
- ☐ 2 years to less than 3 years ago
- ☐ 3 or more years ago
- ☐ Never
- ☐ Don't know

HS07 Have you ever had a polyp removed from your colon? *A polyp is an abnormal growth of tissue.*

- ☐ Yes
- ☐ No
- ☐ Don't know

WOMEN - please **skip** to WOMEN'S HEALTH - WH01 on next page

MEN'S HEALTH

MH01 When was the **last** time you had a PSA blood test? *A PSA test is a specific blood test ordered by a doctor to test men for prostate cancer.*

- ☐ Less than 6 months ago
- ☐ 6 months to less than 1 year ago
- ☐ 1 year to less than 2 years ago
- ☐ 2 years to less than 3 years ago
- ☐ 3 or more years ago
- ☐ Never
- ☐ Don't know

MH02 How many children have you fathered, including live births only?

_____ Children

- ☐ Don't know

MEN - please **skip** to **PERSONAL MEDICAL HISTORY – PM01** on page 09

WOMEN'S HEALTH

WH01 How old were you when you had your first menstrual period?

____ Age at first menstrual period

☐ Never had a menstrual period

☐ Don't know

WH02 Have you ever used any hormonal contraceptives for any reason? *Hormonal contraceptives include birth control pills, implants, patches, injections, and rings or intra-uterine devices that release female hormones.*

☐ Yes

☐ No ***Skip** to WHO5 on this page*

☐ Don't know ***Skip** to WHO5 on this page*

WH03 How old were you when you started using hormonal contraceptives?

____ Age when started using hormonal contraceptives

☐ Don't know

WH04 **In total**, how many years or months did you use or have you been using hormonal contraceptives? *Add up all the time that you used contraceptives even if you started and stopped several times.*

_____ Years **OR** _____ Months

☐ Don't know

WH05 How many times have you been pregnant, including live births, stillbirths, spontaneous miscarriages or therapeutic abortions?

___Number of pregnancies

☐ Never been pregnant **Skip** *to WH12 on next page*

☐ Don't know **Skip** *to WH12 on next page*

WH06 How old were you when you first became pregnant?

___Age at first pregnancy

☐ Don't know

WH07 Are you currently pregnant?

☐ Yes - In what week are you? _____ Weeks *If **YES** and it's your first pregnancy, **skip** to WH12 on next page.*

☐ No

☐ Don't know

WH08 Of your pregnancies, how many went to 20 weeks or more? *Please include all pregnancies, regardless of outcome.*

___ Pregnancies

☐ Don't know

WH09 How many children have you given birth to, considering live births only?

___Live births

☐ Don't know

WH10 How old were you when you last became pregnant?

___Age at last pregnancy

☐ Don't know

WH11 In **total**, for how many months did you breastfeed or nurse your child or children? *Think about **all** the children you breastfed and the **total** number of months that you breastfed. Take the number of months that you breastfed each child and add them together. If you did not breastfeed any children, enter "0".*

___ Months

☐ Don't know

WH12 Have you ever received hormone fertility treatment to help you get pregnant?

☐ Yes

☐ No

☐ Don't know

WH13 Have you gone through menopause, meaning that your menstrual periods stopped for **at least one year** and did **not** restart?

☐ Yes, natural menopause

☐ Yes, other reasons (surgery, chemotherapy, medication)

☐ No ***Skip** to WH18 on next page*

☐ Don't know ***Skip** to WH18 on next page*

WH14 How old were you when your menstrual periods stopped for at least one year and did not restart?

___ Age when menstrual periods stopped

☐ Don't know

WH15 Have you ever used hormone replacement therapy (HRT) for any reason?
*Hormone replacement therapy includes progesterone and/or estrogen. It includes all forms such as patches, rings, creams and other topical forms prescribed by a doctor. It **does not** include thyroid hormone treatment or hormonal contraceptives and it **does not** include other 'natural' treatments that can be bought over the counter.*

- ☐ Yes
- ☐ No — ***Skip** to WH18 on this page*
- ☐ Don't know — ***Skip** to WH18 on this page*

WH16 How old were you when you started using hormone replacement therapy?

___ Age when started using hormone replacement therapy

- ☐ Don't know

WH17 In **total**, for how many years or months did you use, or have you been using hormone replacement therapy*? Add up all the time that you used hormone replacement therapy even if you started and stopped several times.*

___ Years **OR** ___ Months

- ☐ Don't know

WH18 Have you ever had a hysterectomy (*an operation to have your uterus or womb removed)?*

- ☐ Yes
- ☐ No — ***Skip** to WH20 on this page*
- ☐ Don't know — ***Skip** to WH20 on this page*

WH19 How old were you when you had your hysterectomy?

___ Age at hysterectomy

- ☐ Don't know

WH20 Have you ever had an operation to have your ovaries removed?

- ☐ Yes
- ☐ No — ***Skip** to WH24 on next page*
- ☐ Don't know — ***Skip** to WH24 on next page*

WH21 Did you have one or both ovaries removed?

- ☐ Both
- ☐ One
- ☐ Don't know

WH22 Were both of your ovaries removed at the **same time**?

- ☐ Yes
- ☐ No
- ☐ Don't know

WH23 How old were you when you had the last surgery?

____Age at last surgery

- ☐ Don't know

WH24 When was the **last** time you had a mammogram? *A mammogram is a low dose x-ray of the breast in a device that compresses and flattens the breast and is used as a screening test for breast cancer*.

- ☐ Less than 6 months ago
- ☐ 6 months to less than 1 year ago
- ☐ 1 year to less than 2 years ago
- ☐ 2 years to less than 3 years ago
- ☐ 3 or more years ago
- ☐ Never
- ☐ Don't know

WH25 When was the **last** time you had a Pap test or a smear test? *A Pap test (sometimes called a cervical smear) is a test performed by a doctor or a nurse where a sample of cells is taken from the cervix*.

- ☐ Less than 6 months ago
- ☐ 6 months to less than 1 year ago
- ☐ 1 year to less than 2 years ago
- ☐ 2 years to less than 3 years ago
- ☐ 3 or more years ago
- ☐ Never
- ☐ Don't know

PERSONAL MEDICAL HISTORY

PM01 Has a doctor ever told you that you had any of the following conditions? *If yes, please provide your **age** when you were first diagnosed.*

a. High blood pressure (not including hypertension during pregnancy)

☐ Yes ☐ No ☐ Don't Know If yes, age at first diagnosis ____ ☐ Don't Know

b. Heart attack (myocardial infarction)

☐ Yes ☐ No ☐ Don't Know If yes, age at first diagnosis ____ ☐ Don't Know

c. Stroke

☐ Yes ☐ No ☐ Don't Know If yes, age at first diagnosis ____ ☐ Don't Know

d. Asthma

☐ Yes ☐ No ☐ Don't Know If yes, age at first diagnosis ____ ☐ Don't Know

e. Chronic obstructive pulmonary disease

☐ Yes ☐ No ☐ Don't Know If yes, age at first diagnosis ____ ☐ Don't Know

f. Major depression

☐ Yes ☐ No ☐ Don't Know If yes, age at first diagnosis ____ ☐ Don't Know

g. Diabetes

☐ Yes ☐ No ☐ Don't Know If yes, age at first diagnosis ____ ☐ Don't Know

If YES, which **type** of Diabetes was it?

- ☐ Gestational diabetes **only**
- ☐ Type 1 diabetes
- ☐ Type 2 diabetes
- ☐ Don't know

h. Liver cirrhosis

☐ Yes ☐ No ☐ Don't Know If yes, age at first diagnosis ____ ☐ Don't Know

i. Chronic hepatitis

☐ Yes ☐ No ☐ Don't Know If yes, age at first diagnosis ____ ☐ Don't Know

j. Crohn's disease

☐ Yes ☐ No ☐ Don't Know If yes, age at first diagnosis ____ ☐ Don't Know

k. Ulcerative colitis

☐ Yes ☐ No ☐ Don't Know If yes, age at first diagnosis ____ ☐ Don't Know

l. Irritable bowel disease

☐ Yes ☐ No ☐ Don't Know If yes, age at first diagnosis ____ ☐ Don't Know

m. Eczema

☐ Yes ☐ No ☐ Don't Know If yes, age at first diagnosis ____ ☐ Don't Know

n. Lupus

☐ Yes ☐ No ☐ Don't Know If yes, age at first diagnosis ____ ☐ Don't Know

o. Psoriasis

☐ Yes ☐ No ☐ Don't Know If yes, age at first diagnosis ____ ☐ Don't Know

p. Multiple sclerosis

☐ Yes ☐ No ☐ Don't Know If yes, age at first diagnosis ____ ☐ Don't Know

q. Osteoporosis

☐ Yes ☐ No ☐ Don't Know If yes, age at first diagnosis ____ ☐ Don't Know

r. Arthritis

☐ Yes ☐ No ☐ Don't Know If yes, age at first diagnosis ____ ☐ Don't Know

If YES, which **type** of arthritis was it?

☐ Rheumatoid arthritis

☐ Osteoarthritis

☐ Other, please specify _____

☐ Don't Know

PM02 Has a doctor ever told you that you had cancer or a malignancy of any kind?

☐ Yes

☐ No ***Skip** to PM04 on page 13*

☐ Don't know ***Skip** to PM04 on page 13*

PM03 What **type** of cancer was it and how **old** were you when the cancer was **first** diagnosed?
If you have had cancer more than once, please select each one separately.

First type of Cancer

Bladder	If yes, age at first diagnosis_____	☐ Don't Know
Brain	If yes, age at first diagnosis_____	☐ Don't Know
Breast	If yes, age at first diagnosis_____	☐ Don't Know
Cervix	If yes, age at first diagnosis_____	☐ Don't Know
Colon	If yes, age at first diagnosis_____	☐ Don't Know
Esophagus	If yes, age at first diagnosis_____	☐ Don't Know
Kidney	If yes, age at first diagnosis_____	☐ Don't Know
Larynx	If yes, age at first diagnosis_____	☐ Don't Know
Leukemia	If yes, age at first diagnosis_____	☐ Don't Know
Liver	If yes, age at first diagnosis_____	☐ Don't Know
Lung and Bronchus	If yes, age at first diagnosis_____	☐ Don't Know
Non-Hodgkin Lymphoma	If yes, age at first diagnosis_____	☐ Don't Know
Lymphoma	If yes, age at first diagnosis_____	☐ Don't Know
Ovary	If yes, age at first diagnosis_____	☐ Don't Know
Pancreas	If yes, age at first diagnosis_____	☐ Don't Know

Prostate	If yes, age at first diagnosis_____	☐ Don't Know
Rectum	If yes, age at first diagnosis_____	☐ Don't Know
Skin	If yes, age at first diagnosis_____	☐ Don't Know
Stomach	If yes, age at first diagnosis_____	☐ Don't Know
Thyroid	If yes, age at first diagnosis_____	☐ Don't Know
Trachea	If yes, age at first diagnosis_____	☐ Don't Know
Uterus	If yes, age at first diagnosis_____	☐ Don't Know
Other, please specify _____		☐ Don't Know

Treatment

Did you receive treatment for this cancer?

- ☐ Yes
- ☐ No
- ☐ Don't know

Type of treatment

What type of treatment was it? *(Choose **ALL** that apply)*

- ☐ Chemotherapy
- ☐ Radiation
- ☐ Surgery
- ☐ Other, please specify _____
- ☐ Don't know

Second type of Cancer

Bladder	If yes, age at first diagnosis_____	☐ Don't Know
Brain	If yes, age at first diagnosis_____	☐ Don't Know
Breast	If yes, age at first diagnosis_____	☐ Don't Know
Cervix	If yes, age at first diagnosis_____	☐ Don't Know
Colon	If yes, age at first diagnosis_____	☐ Don't Know
Esophagus	If yes, age at first diagnosis_____	☐ Don't Know
Kidney	If yes, age at first diagnosis_____	☐ Don't Know
Larynx	If yes, age at first diagnosis_____	☐ Don't Know
Leukemia	If yes, age at first diagnosis_____	☐ Don't Know
Liver	If yes, age at first diagnosis_____	☐ Don't Know
Lung and Bronchus	If yes, age at first diagnosis_____	☐ Don't Know
Non-Hodgkin Lymphoma	If yes, age at first diagnosis_____	☐ Don't Know
Lymphoma	If yes, age at first diagnosis_____	☐ Don't Know
Ovary	If yes, age at first diagnosis_____	☐ Don't Know

Pancreas	If yes, age at first diagnosis_____	☐ Don't Know
Prostate	If yes, age at first diagnosis_____	☐ Don't Know
Rectum	If yes, age at first diagnosis_____	☐ Don't Know
Skin	If yes, age at first diagnosis_____	☐ Don't Know
Stomach	If yes, age at first diagnosis_____	☐ Don't Know
Thyroid	If yes, age at first diagnosis_____	☐ Don't Know
Trachea	If yes, age at first diagnosis_____	☐ Don't Know
Uterus	If yes, age at first diagnosis_____	☐ Don't Know
Other, please specify _____		☐ Don't Know

Treatment

Did you receive treatment for this cancer?

- ☐ Yes
- ☐ No
- ☐ Don't know

Type of treatment

What type of treatment was it? *(Choose **ALL** that apply)*

- ☐ Chemotherapy
- ☐ Radiation
- ☐ Surgery
- ☐ Other, please specify _____
- ☐ Don't know

Third type of Cancer

Bladder	If yes, age at first diagnosis_____	☐ Don't Know
Brain	If yes, age at first diagnosis_____	☐ Don't Know
Breast	If yes, age at first diagnosis_____	☐ Don't Know
Cervix	If yes, age at first diagnosis_____	☐ Don't Know
Colon	If yes, age at first diagnosis_____	☐ Don't Know
Esophagus	If yes, age at first diagnosis_____	☐ Don't Know
Kidney	If yes, age at first diagnosis_____	☐ Don't Know
Larynx	If yes, age at first diagnosis_____	☐ Don't Know
Leukemia	If yes, age at first diagnosis_____	☐ Don't Know
Liver	If yes, age at first diagnosis_____	☐ Don't Know
Lung and Bronchus	If yes, age at first diagnosis_____	☐ Don't Know
Non-Hodgkin Lymphoma	If yes, age at first diagnosis_____	☐ Don't Know
Lymphoma	If yes, age at first diagnosis_____	☐ Don't Know

Ovary	If yes, age at first diagnosis_____	☐ Don't Know
Pancreas	If yes, age at first diagnosis_____	☐ Don't Know
Prostate	If yes, age at first diagnosis_____	☐ Don't Know
Rectum	If yes, age at first diagnosis_____	☐ Don't Know
Skin	If yes, age at first diagnosis_____	☐ Don't Know
Stomach	If yes, age at first diagnosis_____	☐ Don't Know
Thyroid	If yes, age at first diagnosis_____	☐ Don't Know
Trachea	If yes, age at first diagnosis_____	☐ Don't Know
Uterus	If yes, age at first diagnosis_____	☐ Don't Know
Other, please specify _____		☐ Don't Know

Treatment

Did you receive treatment for this cancer?

- ☐ Yes
- ☐ No
- ☐ Don't know

Type of treatment

What type of treatment was it? *(Choose **ALL** that apply)*

- ☐ Chemotherapy
- ☐ Radiation
- ☐ Surgery
- ☐ Other, please specify _____
- ☐ Don't know

PM04 Do you have or have you had any other **long-term health conditions**?

- ☐ Yes
- ☐ No ***Skip** to Prescribed Medication ME01 on next page*
- ☐ Don't know ***Skip** to Prescribed Medication ME01 on next page*

If Yes, please list these long-term conditions

Long term condition 1 _____

Long term condition 2 _____

Long term condition 3 _____

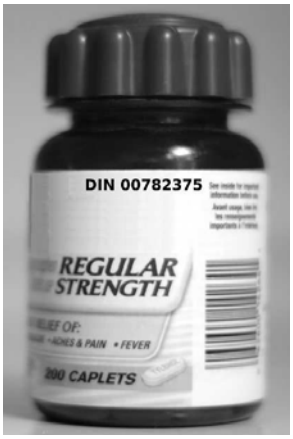
PRESCRIBED MEDICATIONS

ME01 Are you **currently** taking any medications prescribed by a doctor and dispensed by a pharmacist? *Prescription medication could include such things as insulin, nicotine patches, birth control (pills, patches or injections) and other hormonal therapies.*

- ☐ Yes
- ☐ No — ***Skip** to Family Medical History FM01 on next page*
- ☐ Don't know — ***Skip** to Family Medical History FM01 on next page*

For **each** prescribed medication that you are currently taking, please write down the name of the medication and the drug identification number (DIN).

If you have access to the bottles and containers, write down the name of each medication and DIN from the label. The DIN is an 8 digit number that should be printed on the label that is attached to the container by the pharmacist. It is **NOT** the prescription number.



	Name of the Medication	Drug Identification Number (DIN)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

FAMILY HEALTH HISTORY

For your family health history, please **ONLY** include your **immediate blood relatives**, including mother, father, children, full and half brothers and sisters. Do **not** include relatives by marriage, step-brothers and step-sisters, parents by adoption, step-children or adopted children.

FM01 Have any of your **immediate blood relatives** ever been diagnosed by a medical doctor with any of the following long-term health conditions?

Mother

Heart attack (myocardial infarction)	☐	Yes	☐	No	☐	Don't Know
Stroke	☐	Yes	☐	No	☐	Don't Know
Diabetes	☐	Yes	☐	No	☐	Don't Know
Chronic obstructive pulmonary disease	☐	Yes	☐	No	☐	Don't Know
High blood pressure	☐	Yes	☐	No	☐	Don't Know
Asthma	☐	Yes	☐	No	☐	Don't Know
Major depression	☐	Yes	☐	No	☐	Don't Know
Liver cirrhosis	☐	Yes	☐	No	☐	Don't Know
Chronic hepatitis	☐	Yes	☐	No	☐	Don't Know
Crohn's disease	☐	Yes	☐	No	☐	Don't Know
Ulcerative colitis	☐	Yes	☐	No	☐	Don't Know
Irritable bowel disease	☐	Yes	☐	No	☐	Don't Know
Eczema	☐	Yes	☐	No	☐	Don't Know
Lupus	☐	Yes	☐	No	☐	Don't Know
Psoriasis	☐	Yes	☐	No	☐	Don't Know
Multiple sclerosis	☐	Yes	☐	No	☐	Don't Know
Osteoporosis	☐	Yes	☐	No	☐	Don't Know
Arthritis	☐	Yes	☐	No	☐	Don't Know

Father

Heart attack (myocardial infarction)	☐	Yes	☐	No	☐	Don't Know
Stroke	☐	Yes	☐	No	☐	Don't Know
Diabetes	☐	Yes	☐	No	☐	Don't Know
Chronic obstructive pulmonary disease	☐	Yes	☐	No	☐	Don't Know
High blood pressure	☐	Yes	☐	No	☐	Don't Know
Asthma	☐	Yes	☐	No	☐	Don't Know
Major depression	☐	Yes	☐	No	☐	Don't Know

Liver cirrhosis	☐ Yes	☐ No	☐ Don't Know
Chronic hepatitis	☐ Yes	☐ No	☐ Don't Know
Crohn's disease	☐ Yes	☐ No	☐ Don't Know
Ulcerative colitis	☐ Yes	☐ No	☐ Don't Know
Irritable bowel disease	☐ Yes	☐ No	☐ Don't Know
Eczema	☐ Yes	☐ No	☐ Don't Know
Lupus	☐ Yes	☐ No	☐ Don't Know
Psoriasis	☐ Yes	☐ No	☐ Don't Know
Multiple sclerosis	☐ Yes	☐ No	☐ Don't Know
Osteoporosis	☐ Yes	☐ No	☐ Don't Know
Arthritis	☐ Yes	☐ No	☐ Don't Know

Siblings

☐ I do not have any siblings

Heart attack (myocardial infarction)	☐ Yes	☐ If yes, # of siblings	☐ No	☐ Don't Know
Stroke	☐ Yes	☐ If yes, # of siblings	☐ No	☐ Don't Know
Diabetes	☐ Yes	☐ If yes, # of siblings	☐ No	☐ Don't Know
Chronic obstructive pulmonary disease	☐ Yes	☐ If yes, # of siblings	☐ No	☐ Don't Know
High blood pressure	☐ Yes	☐ If yes, # of siblings	☐ No	☐ Don't Know
Asthma	☐ Yes	☐ If yes, # of siblings	☐ No	☐ Don't Know
Major depression	☐ Yes	☐ If yes, # of siblings	☐ No	☐ Don't Know
Liver cirrhosis	☐ Yes	☐ If yes, # of siblings	☐ No	☐ Don't Know
Chronic hepatitis	☐ Yes	☐ If yes, # of siblings	☐ No	☐ Don't Know
Chrohn's disease	☐ Yes	☐ If yes, # of siblings	☐ No	☐ Don't Know
Ulcerative colitis	☐ Yes	☐ If yes, # of siblings	☐ No	☐ Don't Know
Irritable bowel disease	☐ Yes	☐ If yes, # of siblings	☐ No	☐ Don't Know
Eczema	☐ Yes	☐ If yes, # of siblings	☐ No	☐ Don't Know
Lupus	☐ Yes	☐ If yes, # of siblings	☐ No	☐ Don't Know
Psoriasis	☐ Yes	☐ If yes, # of siblings	☐ No	☐ Don't Know
Multiple sclerosis	☐ Yes	☐ If yes, # of siblings	☐ No	☐ Don't Know
Osteoporosis	☐ Yes	☐ If yes, # of siblings	☐ No	☐ Don't Know
Arthritis	☐ Yes	☐ If yes, # of siblings	☐ No	☐ Don't Know

Children

☐ I do not have any children

Heart attack (myocardial infarction)	☐ Yes	☐ If yes, # of children	☐ No	☐ Don't Know
Stroke	☐ Yes	☐ If yes, # of children	☐ No	☐ Don't Know
Diabetes	☐ Yes	☐ If yes, # of children	☐ No	☐ Don't Know
Chronic obstructive pulmonary disease	☐ Yes	☐ If yes, # of children	☐ No	☐ Don't Know
High blood pressure	☐ Yes	☐ If yes, # of children	☐ No	☐ Don't Know
Asthma	☐ Yes	☐ If yes, # of children	☐ No	☐ Don't Know
Major depression	☐ Yes	☐ If yes, # of children	☐ No	☐ Don't Know
Liver cirrhosis	☐ Yes	☐ If yes, # of children	☐ No	☐ Don't Know
Chronic hepatitis	☐ Yes	☐ If yes, # of children	☐ No	☐ Don't Know
Chrohn's disease	☐ Yes	☐ If yes, # of children	☐ No	☐ Don't Know
Ulcerative colitis	☐ Yes	☐ If yes, # of children	☐ No	☐ Don't Know
Irritable bowel disease	☐ Yes	☐ If yes, # of children	☐ No	☐ Don't Know
Eczema	☐ Yes	☐ If yes, # of children	☐ No	☐ Don't Know
Lupus	☐ Yes	☐ If yes, # of children	☐ No	☐ Don't Know
Psoriasis	☐ Yes	☐ If yes, # of children	☐ No	☐ Don't Know
Multiple sclerosis	☐ Yes	☐ If yes, # of children	☐ No	☐ Don't Know
Osteoporosis	☐ Yes	☐ If yes, # of children	☐ No	☐ Don't Know
Arthritis	☐ Yes	☐ If yes, # of children	☐ No	☐ Don't Know

FM02 Have any of your **immediate blood relatives**, including mother, father, children, full and half brothers and sisters ever been diagnosed with cancer?

☐ Yes

☐ No ***Skip** to Sleep Pattern SP01 on Page 20*

☐ Don't know ***Skip** to Sleep Pattern SP01 on Page 20*

FM03 Has your **biological** mother ever been diagnosed with cancer?

☐ Yes

☐ No ***Skip** to FM05 on next page*

☐ Don't know ***Skip** to FM05 on next page*

FM04 Which of the following **types** of cancer was your mother diagnosed with? Choose **ALL** that apply.

- ☐ Bladder
- ☐ Brain
- ☐ Breast
- ☐ Cervix
- ☐ Colon
- ☐ Esophagus
- ☐ Kidney
- ☐ Larynx
- ☐ Leukemia
- ☐ Liver
- ☐ Lung and Bronchus
- ☐ Non-Hodgkin Lymphoma
- ☐ Lymphoma
- ☐ Ovary
- ☐ Pancreas
- ☐ Rectum
- ☐ Skin
- ☐ Stomach
- ☐ Thyroid
- ☐ Trachea
- ☐ Uterus

- ☐ Other, please specify _____
- ☐ Don't know

FM05 Has your **biological** father ever been diagnosed with cancer?

- ☐ Yes
- ☐ No — ***Skip** to FM07 on next page*
- ☐ Don't know — ***Skip** to FM07 on next page*

FM06 Which of the following **types** of cancer was your father diagnosed with? Choose **ALL** that apply.

- ☐ Bladder
- ☐ Brain
- ☐ Breast
- ☐ Colon
- ☐ Esophagus
- ☐ Kidney
- ☐ Larynx
- ☐ Leukemia
- ☐ Liver
- ☐ Lung and Bronchus
- ☐ Non-Hodgkin Lymphoma
- ☐ Lymphoma
- ☐ Pancreas
- ☐ Prostate
- ☐ Rectum
- ☐ Skin
- ☐ Stomach
- ☐ Thyroid
- ☐ Trachea

- ☐ Other, please specify _____
- ☐ Don't know

FM07 Have any of your **biological** siblings ever been diagnosed with cancer?

- ☐ Yes — If yes, how many siblings? ____
  - ☐ Don't know how many siblings
- ☐ No — ***Skip*** *to Sleep Pattern on Page 20*
- ☐ Don't know — ***Skip*** *to Sleep Pattern on Page 20*
- ☐ I do not have any siblings — ***Skip*** *to Sleep Pattern on Page 20*

FM08 Have any of your **biological** children ever been diagnosed with cancer?

- ☐ Yes — If yes, how many children? ____
  - ☐ Don't know how many children
- ☐ No — ***Skip*** *to Sleep Pattern on Page 20*
- ☐ Don't know — ***Skip*** *to Sleep Pattern on Page 20*
- ☐ I do not have any siblings — ***Skip*** *to Sleep Pattern on Page 20*

FM09 For your biological siblings and children, please indicate how many siblings and children have been diagnosed with each of the cancer types listed below.

☐ Bladder	_____ # Siblings Diagnosed	_____ # Children Diagnosed
☐ Brain	_____ # Siblings Diagnosed	_____ # Children Diagnosed
☐ Breast	_____ # Siblings Diagnosed	_____ # Children Diagnosed
☐ Cervix	_____ # Siblings Diagnosed	_____ # Children Diagnosed
☐ Colon	_____ # Siblings Diagnosed	_____ # Children Diagnosed
☐ Esophagus	_____ # Siblings Diagnosed	_____ # Children Diagnosed
☐ Kidney	_____ # Siblings Diagnosed	_____ # Children Diagnosed
☐ Larynx	_____ # Siblings Diagnosed	_____ # Children Diagnosed
☐ Leukemia	_____ # Siblings Diagnosed	_____ # Children Diagnosed
☐ Liver	_____ # Siblings Diagnosed	_____ # Children Diagnosed
☐ Lung and Bronchus	_____ # Siblings Diagnosed	_____ # Children Diagnosed
☐ Non-Hodgkin Lymphoma	_____ # Siblings Diagnosed	_____ # Children Diagnosed
☐ Lymphoma	_____ # Siblings Diagnosed	_____ # Children Diagnosed
☐ Ovary	_____ # Siblings Diagnosed	_____ # Children Diagnosed
☐ Pancreas	_____ # Siblings Diagnosed	_____ # Children Diagnosed
☐ Prostate	_____ # Siblings Diagnosed	_____ # Children Diagnosed
☐ Rectum	_____ # Siblings Diagnosed	_____ # Children Diagnosed
☐ Skin	_____ # Siblings Diagnosed	_____ # Children Diagnosed

☐ Stomach	_____ # Siblings Diagnosed	_____ # Children Diagnosed
☐ Thyroid	_____ # Siblings Diagnosed	_____ # Children Diagnosed
☐ Trachea	_____ # Siblings Diagnosed	_____ # Children Diagnosed
☐ Uterus	_____ # Siblings Diagnosed	_____ # Children Diagnosed
☐ Other Please specify type of cancer	_____ # Siblings Diagnosed	_____ # Children Diagnosed
☐ Don't Know	_____ Number of Siblings	_____ Number of Children

SLEEP PATTERN

SP01 On average, how many hours per day do you usually sleep, including naps? *A day refers to a 24 hour period. Please think of the total amount of unbroken sleep.*

_____ Hours **AND** _____ Minutes

☐ Don't know

SP02 How often do you have trouble going to sleep or staying asleep?

☐ Never
☐ Little of the time
☐ Some of the time
☐ Most of the time
☐ All the time
☐ Don't know

SP03 On average, how much light enters your room while you are sleeping?

☐ Virtually no light
☐ Some light
☐ A lot of light
☐ Don't know

SUNLIGHT

SU01 **In the past 12 months,** how many times have you used artificial tanning equipment such as a tanning bed, sunlamp or tanning light for any reason, including medical reasons?

- ☐ Never
- ☐ 1 to 4 times
- ☐ 5 to 9 times
- ☐ 10 to 14 times
- ☐ 15 to 19 times
- ☐ 20 to 24 times
- ☐ 25 or more times
- ☐ Don't know

SU02 After several months of not being in the sun, if you then went out in the sun during the summer in the middle of the day without sunscreen or protective clothing for **one hour**, which one of these would happen to your skin? *If you do not go out in the sun, make your best guess of what would happen if you did.*

- ☐ A severe sunburn with blistering
- ☐ A painful sunburn for a few days followed by peeling
- ☐ Mildly burnt followed by tanning
- ☐ Darker/brown without any sunburn
- ☐ There would be no change
- ☐ Other

SU03 What is your natural hair colour? *If your hair is now grey, please select the colour of your hair before it turned grey. Choose **ONE** only.*

- ☐ Blond
- ☐ Red
- ☐ Light brown
- ☐ Dark brown
- ☐ Black

SU04 What is your natural eye colour? *Choose **ONE** only.*

- ☐ Amber
- ☐ Blue
- ☐ Brown
- ☐ Grey
- ☐ Green
- ☐ Hazel
- ☐ Red (Albino)

FOOD CONSUMED IN A TYPICAL DAY

The next few questions ask about food you eat in a typical day. Since diet is a very important area, we will ask more about this later. Here, we will ask only a few basic questions.

FC01 In a typical day, how many total servings of vegetables do you eat*? A serving of fresh, frozen, canned or cooked leafy vegetables is about 1/2 cup or 125 ml.*

____Servings per day

- ☐ None
- ☐ Don't know

FC02 In a typical day, how many total servings of fruit (not including fruit juice) do you eat? *A serving is about 1/2 cup or 125 ml of fresh, frozen or canned fruit.*

____Servings per day

- ☐ None
- ☐ Don't know

FC03 In a typical day, how many total servings of 100% fruit or vegetable juice do you drink? *This includes mixtures of fruit and vegetable juice, but not fruit drinks or fruit cocktails. A serving of fruit or vegetable juice is about 1/2 cup or 125 ml.*

____Servings per day

- ☐ None
- ☐ Don't know

ALCOHOL USE

AU01 Have you ever consumed alcohol?

- ☐ Yes
- ☐ No — ***Skip*** *to TU01 Tobacco Use* on page 25
- ☐ Don't know — ***Skip*** *to TU01 Tobacco Use* on page 25

AU02 On average, **over the last year**, how often did you drink alcohol?

- ☐ 6 to 7 times a week
- ☐ 4 to 5 times a week
- ☐ 2 to 3 times a week
- ☐ Once a week
- ☐ 2 to 3 times a month — ***Skip*** *to AU05 on page 24*
- ☐ About once a month — ***Skip*** *to AU05 on page 24*
- ☐ Less than monthly — ***Skip*** *to AU05 on page 24*
- ☐ Never — ***Skip*** *to Tobacco Use on page 24*
- ☐ Don't know — ***Skip*** *to Tobacco Use on page 24*

AU03 On average, how many drinks do you have during a typical week? *A standard drink means one glass of wine or a wine cooler (142 ml, 5 ounces), one bottle or can of beer or a glass of draft (341 ml, 12 ounces), one straight or mixed drink with 1.5 ounces (43 ml) of liquor.*

Red Wine	_____ drink(s) per week	☐ None	☐ Don't Know
White Wine	_____ drink(s) per week	☐ None	☐ Don't Know
Beer	_____ drink(s) per week	☐ None	☐ Don't Know
Liquor/Spirits	_____ drink(s) per week	☐ None	☐ Don't Know
Other Alcohol	_____ drink(s) per week	☐ None	☐ Don't Know

AU04 During a typical week, do you drink alcohol mostly on weekend (or non-working) days?

- ☐ Yes
- ☐ No

MEN only, WOMEN **Skip** to AU06

AU05 During the past 12 months, how often did you have five or more drinks at the same sitting or occasion?

- ☐ 6 to 7 times a week
- ☐ 4 to 5 times a week
- ☐ 2 to 3 times a week
- ☐ Once a week
- ☐ 2 to 3 times a month
- ☐ About once a month
- ☐ 6 to 11 times a year
- ☐ 1 to 5 times a year
- ☐ Never
- ☐ Don't know

WOMEN only, MEN **Skip** to TOBACCO USE below

AU06 During the past 12 months, how often did you have four or more drinks at the same sitting or occasion?

- ☐ 6 to 7 times a week
- ☐ 4 to 5 times a week
- ☐ 2 to 3 times a week
- ☐ Once a week
- ☐ 2 to 3 times a month
- ☐ About once a month
- ☐ 6 to 11 times a year
- ☐ 1 to 5 times a year
- ☐ Never
- ☐ Don't know

TOBACCO USE

This section is about tobacco. The first questions are about **CIGARETTE SMOKING**. *The term "cigarette" refers to cigarettes that are bought ready-made as well as those you roll yourself. Do not include cigars, cigarillos or pipes when you answer these first questions about cigarettes.*

In this section, please **read the directions carefully**. There are different "paths" for non-smokers, daily smokers, and occasional smokers.

TU01 Have you smoked at least 100 cigarettes in your life? *(About 4 - 5 packs)*

- ☐ Yes — ***Skip*** *to TU03 on this page*
- ☐ No
- ☐ Don't know

TU02 Have you ever smoked a whole cigarette?

- ☐ Yes
- ☐ No — ***Skip*** *to TU16 on page 27*
- ☐ Don't know — ***Skip*** *to TU16 on page 27*

TU03 At what age did you smoke your **first** whole cigarette?

____Age

TU04 At the present time, do you smoke cigarettes daily, occasionally, or not at all?

- ☐ Daily (a*t least one cigarette every day for the past 30 days)*
  Skip *to TU05 on this page*
- ☐ Occasionally (a*t least one cigarette in the past 30 days, but not every day)*
  Skip *to TU09 on next page*
- ☐ Not at all (*You did not smoke at all in the past 30 days)*
  Skip *to TU11 on next page*

TU05 At what age did you begin smoking cigarettes daily?

_____Age

TU06 How many cigarettes do you smoke each day now?

- ☐ 1 - 5 cigarettes
- ☐ 6 - 10 cigarettes
- ☐ 11 - 15 cigarettes
- ☐ 16 - 20 cigarettes
- ☐ 21 - 25 cigarettes
- ☐ 26+ cigarettes If 26+, how many? _____

TU07 For how many total years have you smoked daily?

____ Years

TU08 During the total years that you have smoked daily, about how many cigarettes per day have you usually smoked*? (If your smoking pattern has changed over the years, make your best guess of the average number of cigarettes you have smoked per day.)*

- ☐ 1 - 5 cigarettes
- ☐ 6 - 10 cigarettes
- ☐ 11 - 15 cigarettes
- ☐ 16 - 20 cigarettes
- ☐ 21 - 25 cigarettes
- ☐ 26+ cigarettes If 26+, how many? _____

If **you currently smoke daily SKIP** TO ***TU16 on page 27***

TU09 On how many of the last 30 days did you smoke at least one cigarette?

- ☐ 1 - 5 days
- ☐ 6 - 10 days
- ☐ 11 - 20 days
- ☐ 21 - 29 days

TU10 On the days that you smoked, how many cigarettes did you usually smoke?

- ☐ 1 - 5 cigarettes
- ☐ 6 - 10 cigarettes
- ☐ 11 - 15 cigarettes
- ☐ 16 - 20 cigarettes
- ☐ 21 - 25 cigarettes
- ☐ 26+ cigarettes

TU11 Have you ever smoked cigarettes daily? *(At least one cigarette a day for 30 days in a row)*

- ☐ Yes
- ☐ No ***Skip** to TU16 on page 27*
- ☐ Don't know ***Skip** to TU16 on page 27*

TU12 At what age did you begin to smoke daily?

_____Age

TU13 When you smoked daily, how many cigarettes did you usually smoke each day?

- ☐ 1 - 5 cigarettes
- ☐ 6 - 10 cigarettes
- ☐ 11 - 15 cigarettes
- ☐ 16 - 20 cigarettes
- ☐ 21 - 25 cigarettes
- ☐ 26+ cigarettes If 26+, how many? _____

TU14 For how many total years did you smoke daily?

_____ Years

TU15 When did you stop smoking cigarettes daily?

- ☐ Less than 1 year ago
- ☐ 1 to 2 years ago
- ☐ 3 to 5 years ago
- ☐ More than 5 years ago
- ☐ Don't know

Everyone answers the last questions.

TU16 **In your lifetime**, have you ever used other types of tobacco on a regular basis and for a period of at least six months?

- ☐ Yes
- ☐ No ***Skip*** *to ET01 Environmental Tobacco Smoke on Page 28*
- ☐ Don't Know ***Skip*** *to ET01 Environmental Tobacco Smoke on Page 28*

TU17 What other types of products listed below have you ever used on a regular basis and for a period of at least six months?

Cigars	☐ Yes	☐ No	☐ Don't Know
Small cigars (cigarillos)	☐ Yes	☐ No	☐ Don't Know
Tobacco pipes	☐ Yes	☐ No	☐ Don't Know
Chewing tobacco or snuff	☐ Yes	☐ No	☐ Don't Know
Nicotine patches	☐ Yes	☐ No	☐ Don't Know
Nicotine gum	☐ Yes	☐ No	☐ Don't Know
Betel nut	☐ Yes	☐ No	☐ Don't Know

Paan	☐ Yes	☐ No	☐ Don't Know
Sheesha	☐ Yes	☐ No	☐ Don't Know
Other, please specify			

TU18 Do you currently use any other types of products listed below?

Cigars	☐ Yes	☐ No	☐ Don't Know
Small cigars (cigarillos)	☐ Yes	☐ No	☐ Don't Know
Tobacco pipes	☐ Yes	☐ No	☐ Don't Know
Chewing tobacco or snuff	☐ Yes	☐ No	☐ Don't Know
Nicotine patches	☐ Yes	☐ No	☐ Don't Know
Nicotine gum	☐ Yes	☐ No	☐ Don't Know
Betel nut	☐ Yes	☐ No	☐ Don't Know
Paan	☐ Yes	☐ No	☐ Don't Know
Sheesha	☐ Yes	☐ No	☐ Don't Know
Other, please specify			

ENVIRONMENTAL TOBACCO SMOKE

ET01 From birth **until the age** of 18, how many years did you live with a person who smoked cigarettes, cigars or pipes **inside your home**?

____Years

☐ None

☐ Don't know

ET02 As an adult, **from age 18 years to now**, how many years did you live with a person who smoked cigarettes, cigars or pipes **inside your home?**

____Years

☐ None

☐ Don't know

ET03 At home, how often are you usually exposed to other people's tobacco smoke **inside your home**?

- ☐ Every day
- ☐ Almost every day
- ☐ At least once a week
- ☐ At least once a month
- ☐ Less than once a month
- ☐ Never
- ☐ Don't know

ET04 During leisure time **outside of your home**, how often are you usually exposed to other people's tobacco smoke?

- ☐ Every day
- ☐ Almost every day
- ☐ At least once a week
- ☐ At least once a month
- ☐ Less than once a month
- ☐ Never
- ☐ Don't know

ET05 As an adult, from **age 18 years to now**, how many years did you regularly **work** in an environment where other people smoked cigarettes, cigars or pipes in your presence?

____Years

- ☐ None
- ☐ Don't know

ET06 **At work**, how often are you usually exposed to other people's tobacco smoke?

- ☐ Every day
- ☐ Almost every day
- ☐ At least once a week
- ☐ At least once a month
- ☐ Less than once a month
- ☐ Never
- ☐ Don't know

PHYSICAL ACTIVITY QUESTIONNAIRE

We are interested in finding out about the kinds of physical activities that people do as part of their everyday lives. The questions will ask you about the time you spent being physically active in the **last 7 days**.

- Please answer each question even if you do not consider yourself to be an active person.

- Please think about the activities you do **at work**, as part of your **house and yard work**, **to get from place to place**, and in your **spare time** for recreation, exercise or sport.

Think about all the **vigorous** activities that you did in the **last 7 days**. Vigorous physical activities refer to activities that take hard physical effort and make you breathe much harder than normal. Think only about those physical activities that you did for at least 10 minutes at a time.

PA01 During the **last 7 days**, on how many days did you do **vigorous** physical activities, like heavy lifting, digging, aerobics, or fast bicycling?

____days per week

☐ No vigorous physical activities ***Skip** to PA03 on this page.*

PA02 How much time did you usually spend doing **vigorous** physical activities on one of those days?

____hours per day AND ____minutes per day

☐ Don't know/Not sure

Think about all the **moderate** activities that you did in the **last 7 days**. Moderate activities refer to activities that take moderate physical effort and make you breathe somewhat harder than normal. Think only about those physical activities that you did for at least 10 minutes at a time.

PA03 During the **last 7 days**, on how many days did you do **moderate** physical activities like carrying light loads, bicycling at a regular pace, or doubles tennis? Do not include walking.

____days per week

☐ No moderate physical activities ***Skip** to PA05 on next page*

PA04 How much time did you usually spend doing **moderate** physical activities on one of those days?

____hours per day AND ____minutes per day

☐ Don't know/Not sure

Think about the time you spent **walking** in the **last 7 days**. This includes at work and at home, walking to travel from place to place, and any other walking that you might do solely for recreation, sport, exercise, or leisure.

PA05 During the **last 7 days**, on how many days did you **walk** for at least 10 minutes at a time?

____days per week

☐ No Walking ***Skip** to PA07 below*

PA06 How much time did you usually spend **walking** on one of those days?

___hours per day AND ____minutes per day

☐ Don't know/Not sure

The last questions are about the time you spent **sitting** on weekdays and weekend days during the **last 7 days**. Include time spent at work, at home, while doing course work and during leisure time. This may include time spent sitting at a desk, visiting friends, reading, or sitting or lying down to watch television.

PA07 During the **last 7 days**, how much time did you spend **sitting** on a **week day**?

____hours per day AND ____minutes per day

☐ Don't know/Not sure

PA08 During the **last 7 days**, how much time did you spend **sitting** on a **weekend day**?

____hours per day AND ____minutes per day

☐ Don't know/Not sure

ETHNIC BACKGROUND

EB01 What is your ethnic background and the ethnic background of your biological parents? Please tick **ALL** that apply.

Ethnic background

Aboriginal (e.g., First Nations, Métis, Inuit)	☐ You	☐ Mother	☐ Father
Arab (e.g., Egypt, Iraq, Jordan, Lebanon)	☐ You	☐ Mother	☐ Father
Black (African or Caribbean descent)	☐ You	☐ Mother	☐ Father
East Asian (e.g., China, Japan, Korea, Taiwan)	☐ You	☐ Mother	☐ Father
Filipino	☐ You	☐ Mother	☐ Father
Jewish	☐ You	☐ Mother	☐ Father
Latin American/Hispanic	☐ You	☐ Mother	☐ Father
South Asian (e.g., India, Sri Lanka, Pakistan, Bangladesh)	☐ You	☐ Mother	☐ Father
Southeast Asian (e.g., Malaysia, Indonesia, Vietnam)	☐ You	☐ Mother	☐ Father
West Asian (e.g., Turkey, Iran, Afghanistan)	☐ You	☐ Mother	☐ Father
White (European descent)	☐ You	☐ Mother	☐ Father
Other ethnic group not listed above	☐ You	☐ Mother	☐ Father

EB02 In what country were you and your **biological** parents and grandparents born?
Please tick **ONE** only per person.

Country of birth	You	Mother	Father	Mother's Mother	Mother's Father	Father's Mother	Father's Father
Canada							
China							
France							
Germany							
Greece							
India							
Islamic Republic of Iran							
Ireland							
Italy							
Jamaica							
Republic of Korea							
Philippines							
Poland							
Portugal							
Russian Federation							
Ukraine							
United Kingdom							
United States							
Vietnam							
Other Country Please specify							
Don't Know							

IF YOU WERE BORN IN CANADA SKIP TO RESIDENCE RE01 on next page

EB03 How old were you when you first came to Canada to live?

_____Age when you first came to Canada to live

☐ Don't know

RESIDENCE

RE01 What is your current village/town/city?

_____

RE02 What is your current postal code?

_____

RE03 How old were you when you started living in the dwelling where you live now?

_____Age when you started living at current location

☐ Don't know

RE04 Throughout your life to date, is the dwelling that you live in now the one where you have lived for the **longest period of time**?

☐ Yes

☐ No

☐ Don't know

LANGUAGES

LS01 What is the language that you first learned at home in childhood and can still understand? Choose **ALL** that apply if more than one language was learned at the same time.

- ☐ English
- ☐ French
- ☐ Arabic
- ☐ Aboriginal Language(s)
- ☐ Bengali
- ☐ Cantonese
- ☐ Danish
- ☐ Dutch
- ☐ Farsi/Persian
- ☐ Finnish
- ☐ Gaelic
- ☐ German
- ☐ Greek
- ☐ Hindi
- ☐ Hungarian
- ☐ Icelandic
- ☐ Italian
- ☐ Korean
- ☐ Mandarin
- ☐ Norwegian
- ☐ Polish
- ☐ Portuguese
- ☐ Punjabi
- ☐ Russian
- ☐ Spanish
- ☐ Swedish
- ☐ Tagalog/Filipino
- ☐ Tamil
- ☐ Ukrainian
- ☐ Urdu
- ☐ Vietnamese
- ☐ Welsh

☐ Other, please specify _____

WORKING STATUS

WS01 Which of the following best describes your current employment status? Choose **ALL** that apply. *Full time means 30 hours or more per week. Part time means less than 30 hours per week.*

☐ Full-time employed/self-employed	**Skip** to *WS02* on this page
☐ Part-time employed/self-employed	**Skip** *to WS02* on this page
☐ Retired	**Skip** *to WS07* on next page
☐ Looking after home and/or family	**Skip** *to WS07* on next page
☐ Unable to work because of sickness or disability	**Skip** *to WS07* on next page
☐ Unemployed	**Skip** *to WS07* on next page
☐ Doing unpaid or voluntary work	**Skip** *to WS07* on next page
☐ Student	**Skip** *to WS07* on next page

WS02 What is currently your main job title, meaning the job at which you work the most hours? Give as full a description as you can (e.g., office clerk, factory worker, forestry technician).

_____

☐ Don't know

WS03 What kind of business, industry or service do you work in?

_____

☐ Don't know

WS04 How old were you when you **started** working at your current job?

____Age when you started working at current job

☐ Don't know

WS05 Which one of the following **best describes** your working schedule in your **current** job? *A night shift is work during the early hours of the morning, after midnight. An evening shift is work during the evening ending at or before midnight.* Choose **ONE** only

- ☐ Regular daytime schedule or shift
- ☐ Regular evening shift
- ☐ Regular night shift
- ☐ Rotating shift, changing periodically from days to evenings or to nights
- ☐ Split shift, consisting of two or more distinct periods each day
- ☐ Irregular schedule, or on call
- ☐ Other, please specify _____

WS06 Is your current job the one you have worked in for the longest time (most number of years)?

- ☐ Yes ***Skip*** *to Household Income – HI01 on next page*
- ☐ No

WS07 What was the title of the main job that you held for the **longest time**, meaning the one at which you worked the most hours? *Refer to the jobs that you did when you were employed by someone else, or when you were self-employed. Give as full a description as you can (e.g., office clerk, factory worker, forestry technician).*

_____

- ☐ Don't know

WS08 What kind of business, industry or service did you work in for the **longest time** (most number of years)?

_____

- ☐ Don't know

WS09 Which one of the following **best describes** your working schedule for the job that you held for the **longest time**? *A night shift is work during the early hours of the morning, after midnight. An evening shift is work during the evening ending at or before midnight. C*hoose **ONE** only

- ☐ Regular daytime schedule or shift
- ☐ Regular evening shift
- ☐ Regular night shift
- ☐ Rotating shift, changing periodically from days to evenings or to nights
- ☐ Split shift, consisting of two or more distinct periods each day
- ☐ Irregular schedule, or on call
- ☐ Other, please specify _____

HOUSEHOLD INCOME

The next question asks for your household income. We understand that this information is very private but the question is important because it helps to determine whether the study includes a wide range of participants.

HI01 What is the approximate total household income (from all sources) before taxes last year? Please include the total income including salaries, pensions and allowances.

- ☐ Less than $10, 000
- ☐ $10, 000 - $24, 999
- ☐ $25, 000 - $49, 999
- ☐ $50, 000 - $74, 999
- ☐ $75, 000 - $99, 999
- ☐ $100, 000 - $149, 999
- ☐ $150, 000 - $199, 999
- ☐ $200, 000 or more
- ☐ Don't know
- ☐ Prefer not to answer

HI02 How many individuals does that income support, including children, parents and other persons living in your home and outside your home?

____Individuals

☐ Don't know

HI03 How many **adults** (age 18 or older) including yourself are **currently** living in your household?

___Adults

HI04 How many **children** (under 18 years of age) are **currently** living in your household?

____Children

ANTHROPOMETRIC MEASUREMENTS

AM01 Do you regard yourself as being left or right-handed, or ambidextrous? *An ambidextrous person is able to use either hand with equal dexterity.*

- ☐ Left
- ☐ Right
- ☐ Ambidextrous

AM02 Are you able to stand without assistance?

- ☐ Yes
- ☐ No - if you are UNABLE TO STAND WITHOUT ASSISTANCE, this is the end of the questionnaire. Please s**kip** to page 41 and insert today's date.

In this part of the survey, we need you to take measurements of your height, weight, waist and hips. All measures should be taken twice.

Height

- Remove your shoes and any headwear (e.g., hair clips, hat).
- Stand up straight against a wall with your feet together, and your heels, hips and shoulder blades touching the wall.
- Look straight ahead and lay a hardcover book flat on top of your head.
- Use a pencil to make a mark on the wall in line with the bottom edge of the book.
- Measure the distance between the floor and the mark.
- Repeat the measurement. The two measurements should be within a half inch of each other. If not, take a third measurement and record the closest two measurements.
- Record your height in feet and inches.

AM03 First Measurement _____ft _____inches

AM04 Second Measurement _____ft _____inches

Weight

- Adjust your scale to zero.
- Weigh yourself with your clothes off, or wear light clothing.
- Remember to remove your shoes.
- Step on the scale.
- Make sure both feet are fully on the scale.

- Weigh yourself twice. The two weights should be within one pound (or one kilogram) of each other. If not, weigh yourself a third time and record the closer of the two measurements.
- Record your weight in pounds (or kilograms, e.g., 72.2)

AM05 First Measurement _____pounds **OR** _____kilograms

AM06 Second Measurement _____pounds **OR** _____kilograms

WAIST AND HIPS

- Take the next set of measurements ideally unclothed or in loose fitting underwear.
- Stand in front of a mirror to help position the measuring tape correctly.
- Pull the measuring tape tight enough that it does not slide, but not tight enough to indent the skin.
- Record the measurement in inches.

Waist

- This measurement is taken at a specific spot found along your side. To find the spot simply place your thumb under your armpit, then slide your thumb straight down until you find the hip bone (see diagram).
- Place your measuring tape over that spot where your thumb found the bone, then wrap the measuring tape around your middle.
- Look in the mirror and turn in a circle to ensure the measuring tape is level all around and not twisted at any point. Take the measurement, EVEN IF THIS IS NOT YOUR USUAL WAISTLINE.
- Measure twice. The two measurements should be within a half inch of each other. If they are not, take a third measurement and record the closest two measurements.
- Record your measurement to the nearest inch.

AM07 First Measurement _____ft _____inches

AM08 Second Measurement _____ft _____inches

Hips

- Stand in profile to a mirror with your feet shoulder width apart.
- Look for the largest point of your hips and place the measuring tape at that position (see diagram).
- Now turn in a full circle in front of the mirror to be certain the measuring tape is level all the way around your body. Take the measurement.
- Measure twice. The two measurements should be within a half inch of each other. If not, take a third measurement and record the closest two measurements.
- Record the size of your hips to the nearest inch.

AM09 First Measurement _____inches

AM10 Second Measurement _____inches

Thank you for taking the time to complete this survey.

Date completed: DD _____ MM _____ YYYY _____