

The Tomorrow Project

Albertans Studying the Connection Between Lifestyle and Cancer

In partnership with:

The *Canadian Partnership for Tomorrow Project*

STUDY CENTRE QUESTIONNAIRE

Date Survey Completed:

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DD

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MM

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YYYY

67





**Alberta Health
Services**

Office Use Only
Interviewer ID

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Office use only

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L	C	V	QA

37045



Directions for Completing This Questionnaire

The Study Centre Questionnaire is administered by an interviewer, and may take about 5 to 10 minutes to answer.

- If a participant prefers not to answer a specific question, write '**Decline**' beside it.
- Use a **ballpoint pen**.
- Shade in the bubbles completely, like this:
- Write numbers in boxes, like this:

1	2
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If you are writing a single digit where there is more than one box, it does not matter which box you write the number in.
- If you make an error, put an X through the incorrect bubble like this:

Indicate time at which interview began.

HH	MM	:	<input type="checkbox"/>	AM		
		:			<input type="checkbox"/>	PM

INTERPRETIVE INFORMATION

II 1 Have you received chemotherapy treatment in the past 12 months?

- NO
 YES → When was your last chemotherapy treatment?

DD	MM	YYYY			

II 2 Have you received radiation treatment in the past 12 months?

- NO
 YES → When was your last radiation treatment?

DD	MM	YYYY			

II 3 Have you had a blood transfusion in the last 12 months?

- NO
 YES → When was your last blood transfusion?

DD	MM	YYYY			

→ If transfusion was in last 24 hours, EXCLUDED from phlebotomy



II 4 Do you regard yourself as being left or right-handed, or ambidextrous?

- Left-handed
- Right-handed
- Ambidextrous or use both right and left hands equally

II 5 How tall are you?

Feet Inches

Centimetres

II 6 How much do you weigh?

Pounds
 Kilograms

What is your shoe size?

- U.S.A & Canada
- U.K
- Europe

II 7 What time did you wake up today?

HH MM AM
 PM

II 8 When was the last time you had anything to eat or drink, other than plain water?

HH MM AM
 PM

II 9 Have you had a drink containing caffeine in the last 24 hours, including coffee, tea, soft drinks or energy drinks?

- NO
- YES When was the last time you had caffeine?

HH MM AM
 PM

II 10 Have you drunk any beer, wine or liquor in the past 24 hours?

A drink means one bottle or can of beer or a glass of draft (341 ml, 12 ounces), one glass of wine or a wine cooler (142 ml, 5 ounces), and/or one straight or mixed drink with 1½ ounces of liquor.

- NO **SKIP TO II 12 (PAGE 4)**
- YES When was the last time you had a drink of alcohol?

HH MM AM
 PM

II 11 In the past 24 hours, how many drinks of **beer, wine** or **liquor** have you had?



II 12 Have you smoked any cigarettes, cigars, cigarillos or pipes in the past 24 hours?

NO → SKIP to II 14 (THIS PAGE)

YES → What time did you last smoke a cigarette, cigar, cigarillo or pipe? HH MM AM
 PM

II 13 How many **cigarettes, cigars, cigarillos** or **pipes** have you smoked in the past 24 hours?

Type of tobacco product	Total number smoked in past 24 hours
Cigarettes	
Cigars	
Cigarillos	
Pipes	

II 14 Have you taken any **medications, vitamins, nutritional** or **herbal** supplements in the past 72 hours? Include all medications prescribed by a doctor AND medications that are bought 'over the counter', such as Aspirin, Tylenol, cough medicine, etc.

NO

YES → Please complete the table below. Provide as much information as you can about the manufacturer, the name of the product and the **last time** that you took each product

Name and manufacturer of the medication, vitamin, nutritional or herbal supplement	When was the last time you took the medication, vitamin, diet or herbal supplement?
	Date (DD MM) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Time <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> <input type="radio"/> AM <input type="radio"/> PM
	Date (DD MM) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Time <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> <input type="radio"/> AM <input type="radio"/> PM
	Date (DD MM) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> Time <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> <input type="radio"/> AM <input type="radio"/> PM

	Date (DD MM) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Time <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> <input type="radio"/> AM <input type="radio"/> PM
	Date (DD MM) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Time <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> <input type="radio"/> AM <input type="radio"/> PM
	Date (DD MM) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Time <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> <input type="radio"/> AM <input type="radio"/> PM
	Date (DD MM) <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Time <input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/> <input type="radio"/> AM <input type="radio"/> PM

Women ONLY

MEN SKIP TO E 1 (THIS PAGE)

II 15 Have you had a natural menstrual period during the last 3 months?

- YES
- NO
- DON'T KNOW

When did your last period start?

DD MM

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II 16 Are you currently pregnant?

- YES
- NO
- DON'T KNOW

How many weeks pregnant are you?

--	--

Weeks

EXCLUSION INFORMATION

E 1 Do you have any blood clotting disorders such as hemophilia?

- NO
 - YES
- EXCLUDED from phlebotomy

E 2 Have you ever had arm, chest, or breast surgery or surgery to remove lymph nodes from the arm pit area?

NO

YES → On which side? Right Left

→ If both, participant is EXCLUDED from phlebotomy.

→ If right, advise phlebotomist to draw blood from left arm unless participant is excluded by any other criteria.

→ If left, advise phlebotomist to draw blood from right arm unless participant is excluded by any other criteria.

E 3 Are you currently suffering from lymphedema or excessive swelling in either of your arms?

NO

YES → On which side? Right Left

→ If both, participant is EXCLUDED from phlebotomy.

→ If right, advise phlebotomist to draw blood from left arm unless participant is excluded by any other criteria.

→ If left, advise phlebotomist to draw blood from right arm unless participant is excluded by any other criteria.

E 4 Have you donated blood in the last 24 hours?

NO

YES → EXCLUDED from phlebotomy

E 5 Are you allergic to isopropyl alcohol?

NO

YES → EXCLUDED from phlebotomy

Indicate time at which interview was completed.

HH	MM	<input type="radio"/> AM
<input type="text"/>	<input type="text"/>	<input type="radio"/> PM