

**University of Minnesota
American Registry of Radiologic Technologists
National Institutes of Health Collaborative Health Study**

**Division of Epidemiology
University of Minnesota
Minneapolis, Minnesota 55455**

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Directions: Your responses will be read by an optical reader. By carefully observing the few simple rules below, the accurate recording of your responses will be ensured.

- Use black lead pencil only (No. 2½ or softer).
- Do NOT use ink or ballpoint pens.
- Make heavy black marks that fill the circle completely.
- Erase cleanly any answer you wish to change.
- Make no stray marks on the answer sheet.

EXAMPLES

Proper Mark	Improper Marks

This survey contains several questions which ask you to write a response. Please PRINT your response and confine it to the box provided. Other questions ask you to record number answers on a two digit grid. First write the number in the space provided, then mark the circles of the number in the grid below. For example:

A. To record a year (Example: 1916)

1	9	1	6
0	0	0	0
<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input type="radio"/>	<input type="radio"/>
2	2	2	2
3	3	3	3
4	4	4	4
5	5	5	5
6	<input checked="" type="radio"/>	6	6
7	7	7	7
8	8	8	8
9	9	9	9

B. To record a two digit number (Example: 27)

2	7
0	0
<input type="radio"/>	<input type="radio"/>
1	1
<input type="radio"/>	<input type="radio"/>
<input checked="" type="radio"/>	<input type="radio"/>
2	2
<input type="radio"/>	<input type="radio"/>
3	3
<input type="radio"/>	<input type="radio"/>
4	4
<input type="radio"/>	<input type="radio"/>
5	5
<input type="radio"/>	<input type="radio"/>
6	6
<input type="radio"/>	<input type="radio"/>
7	<input checked="" type="radio"/>
<input type="radio"/>	<input type="radio"/>
8	8
<input type="radio"/>	<input type="radio"/>
9	9

C. To record a number less than 10: fill in "0", then the number (Example: 3)

0	3
<input checked="" type="radio"/>	<input type="radio"/>
1	1
<input type="radio"/>	<input type="radio"/>
2	2
<input type="radio"/>	<input type="radio"/>
3	<input checked="" type="radio"/>
<input type="radio"/>	<input type="radio"/>
4	4
<input type="radio"/>	<input type="radio"/>
5	5
<input type="radio"/>	<input type="radio"/>
6	6
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7	7
<input type="radio"/>	<input type="radio"/>
8	8
<input type="radio"/>	<input type="radio"/>
9	9

It is important not to write in the booklet except where indicated. Space has been provided on page 15 for any additional information or comments you may have.

I. GENERAL INFORMATION

1. What is your birth date?

MONTH	DAY	YEAR																																																																																																				
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2. What is your sex?

- Male
 Female

3. Which of the following groups best describes your racial background?

- White, not of Hispanic origin
 Black, not of Hispanic origin
 Hispanic
 American Indian or Alaskan Native
 Asian or Pacific Islander
 Other (describe below →)

PLEASE PRINT — STAY WITHIN BOX

4. About how tall are you without shoes?

FEET	INCHES																																																
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5. About how much do you weigh without clothes or shoes?

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6. How many years of schooling have you completed?

- 1-8 years (grade school)
 9-12 years (high school)
 2 years radiologic technology program (hospital)
 1-4 years college
 Graduate school
 1-3 years vocational education beyond high school
 Something else →

PLEASE PRINT — STAY WITHIN BOX

7. Are you currently married, widowed, divorced or separated, or have you never been married?

- Currently married Divorced or separated
 Widowed Never married

8. Have you smoked at least 100 cigarettes during your entire life?

- Yes No

IF YOU MARKED NO, SKIP TO QUESTION 13.

9. How old were you when you started smoking?

YEARS OLD

--	--

- | | |
|---|---|
| 0 | 0 |
| 1 | 1 |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
| 6 | 6 |
| 7 | 7 |
| 8 | 8 |
| 9 | 9 |

10. Do you smoke cigarettes now?

- Yes No

IF YOU MARKED YES, SKIP TO QUESTION 12.

11. How old were you when you stopped smoking?

YEARS OLD

--	--

- | | |
|---|---|
| 0 | 0 |
| 1 | 1 |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
| 6 | 6 |
| 7 | 7 |
| 8 | 8 |
| 9 | 9 |

12. On the average, how much do you or did you smoke each day?

- Less than 1/2 pack a day
 1/2 to 1 pack a day
 Between 1 and 2 packs a day
 More than 2 packs a day

13. How many drinks of alcoholic beverage (beer, wine, or liquor) do you usually have in a typical week?

- Never drink
 Less than once a week
 1-2 drinks a week
 3-6 drinks a week
 7-10 drinks a week
 11-12 drinks a week
 13-14 drinks a week
 More than 14 drinks a week

14. Have you ever used permanent hair dye regularly in your hair? By regularly we mean at least twice a year for 2 consecutive years. (Please do not include temporary rinses.)

- Yes No

IF YOU MARKED NO, SKIP TO QUESTION 17.

15. About how often did you or do you use permanent hair dyes?

About every week(s)

- | | |
|---|---|
| 0 | 0 |
| 1 | 1 |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
| 6 | 6 |
| 7 | 7 |
| 8 | 8 |
| 9 | 9 |

16. For about how many years have you used permanent hair dye regularly?

About year(s)

- | | |
|---|---|
| 0 | 0 |
| 1 | 1 |
| 2 | 2 |
| 3 | 3 |
| 4 | 4 |
| 5 | 5 |
| 6 | 6 |
| 7 | 7 |
| 8 | 8 |
| 9 | 9 |

17. Are you currently working as a radiologic technologist or radiologic technician?

- Yes
 No

IF YOU MARKED YES, SKIP TO QUESTION 19.

18. Have you ever worked as a radiologic technologist or radiologic technician?

- Yes
 No

IF YOU MARKED NO, SKIP TO QUESTION 25.

19. Please complete the following for all the jobs where you were employed as a radiologic technologist or radiologic technician. Start with your most recent job and end with your first job. Fill in (a) place of employment, (b) name and address of employment, (c) whether or not you wore a dosimeter most of the time, (d) year employment began and the length of employment in years and months. Please include your hospital training program.

<p>1a. Place of employment</p> <p><input type="radio"/> Hospital</p> <p><input type="radio"/> Physician's office</p> <p><input type="radio"/> Other (please specify <input type="checkbox"/>)</p>	<p>c.</p> <p>DOSIMETER</p> <p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>	<p>d. Year began</p> <p>19 <input type="text"/> <input type="text"/></p> <p>0 0</p> <p>1 1</p> <p>2 2</p> <p>3 3</p> <p>4 4</p> <p>5 5</p> <p>6 6</p> <p>7 7</p> <p>8 8</p> <p>9 9</p>	<p>Length of Employment</p> <p>Yrs. Mos.</p> <p><input type="text"/> <input type="text"/> 1</p> <p>0 0 2</p> <p>1 1 3</p> <p>2 2 4</p> <p>3 3 5</p> <p>4 4 6</p> <p>5 5 7</p> <p>6 6 8</p> <p>7 7 9</p> <p>8 8 10</p> <p>9 9 11</p>	<p>5a. Place of employment</p> <p><input type="radio"/> Hospital</p> <p><input type="radio"/> Physician's office</p> <p><input type="radio"/> Other (please specify <input type="checkbox"/>)</p>	<p>c.</p> <p>DOSIMETER</p> <p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>	<p>d. Year began</p> <p>19 <input type="text"/> <input type="text"/></p> <p>0 0</p> <p>1 1</p> <p>2 2</p> <p>3 3</p> <p>4 4</p> <p>5 5</p> <p>6 6</p> <p>7 7</p> <p>8 8</p> <p>9 9</p>	<p>Length of Employment</p> <p>Yrs. Mos.</p> <p><input type="text"/> <input type="text"/> 1</p> <p>0 0 2</p> <p>1 1 3</p> <p>2 2 4</p> <p>3 3 5</p> <p>4 4 6</p> <p>5 5 7</p> <p>6 6 8</p> <p>7 7 9</p> <p>8 8 10</p> <p>9 9 11</p>
<p>b.</p> <p>Name of place of employment</p> <p>Address</p> <p>City State ZIP</p>				<p>b.</p> <p>Name of place of employment</p> <p>Address</p> <p>City State ZIP</p>			
<p>2a. Place of employment</p> <p><input type="radio"/> Hospital</p> <p><input type="radio"/> Physician's office</p> <p><input type="radio"/> Other (please specify <input type="checkbox"/>)</p>	<p>c.</p> <p>DOSIMETER</p> <p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>	<p>d. Year began</p> <p>19 <input type="text"/> <input type="text"/></p> <p>0 0</p> <p>1 1</p> <p>2 2</p> <p>3 3</p> <p>4 4</p> <p>5 5</p> <p>6 6</p> <p>7 7</p> <p>8 8</p> <p>9 9</p>	<p>Length of Employment</p> <p>Yrs. Mos.</p> <p><input type="text"/> <input type="text"/> 1</p> <p>0 0 2</p> <p>1 1 3</p> <p>2 2 4</p> <p>3 3 5</p> <p>4 4 6</p> <p>5 5 7</p> <p>6 6 8</p> <p>7 7 9</p> <p>8 8 10</p> <p>9 9 11</p>	<p>6a. Place of employment</p> <p><input type="radio"/> Hospital</p> <p><input type="radio"/> Physician's office</p> <p><input type="radio"/> Other (please specify <input type="checkbox"/>)</p>	<p>c.</p> <p>DOSIMETER</p> <p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>	<p>d. Year began</p> <p>19 <input type="text"/> <input type="text"/></p> <p>0 0</p> <p>1 1</p> <p>2 2</p> <p>3 3</p> <p>4 4</p> <p>5 5</p> <p>6 6</p> <p>7 7</p> <p>8 8</p> <p>9 9</p>	<p>Length of Employment</p> <p>Yrs. Mos.</p> <p><input type="text"/> <input type="text"/> 1</p> <p>0 0 2</p> <p>1 1 3</p> <p>2 2 4</p> <p>3 3 5</p> <p>4 4 6</p> <p>5 5 7</p> <p>6 6 8</p> <p>7 7 9</p> <p>8 8 10</p> <p>9 9 11</p>
<p>b.</p> <p>Name of place of employment</p> <p>Address</p> <p>City State ZIP</p>				<p>b.</p> <p>Name of place of employment</p> <p>Address</p> <p>City State ZIP</p>			
<p>3a. Place of employment</p> <p><input type="radio"/> Hospital</p> <p><input type="radio"/> Physician's office</p> <p><input type="radio"/> Other (please specify <input type="checkbox"/>)</p>	<p>c.</p> <p>DOSIMETER</p> <p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>	<p>d. Year began</p> <p>19 <input type="text"/> <input type="text"/></p> <p>0 0</p> <p>1 1</p> <p>2 2</p> <p>3 3</p> <p>4 4</p> <p>5 5</p> <p>6 6</p> <p>7 7</p> <p>8 8</p> <p>9 9</p>	<p>Length of Employment</p> <p>Yrs. Mos.</p> <p><input type="text"/> <input type="text"/> 1</p> <p>0 0 2</p> <p>1 1 3</p> <p>2 2 4</p> <p>3 3 5</p> <p>4 4 6</p> <p>5 5 7</p> <p>6 6 8</p> <p>7 7 9</p> <p>8 8 10</p> <p>9 9 11</p>	<p>7a. Place of employment</p> <p><input type="radio"/> Hospital</p> <p><input type="radio"/> Physician's office</p> <p><input type="radio"/> Other (please specify <input type="checkbox"/>)</p>	<p>c.</p> <p>DOSIMETER</p> <p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>	<p>d. Year began</p> <p>19 <input type="text"/> <input type="text"/></p> <p>0 0</p> <p>1 1</p> <p>2 2</p> <p>3 3</p> <p>4 4</p> <p>5 5</p> <p>6 6</p> <p>7 7</p> <p>8 8</p> <p>9 9</p>	<p>Length of Employment</p> <p>Yrs. Mos.</p> <p><input type="text"/> <input type="text"/> 1</p> <p>0 0 2</p> <p>1 1 3</p> <p>2 2 4</p> <p>3 3 5</p> <p>4 4 6</p> <p>5 5 7</p> <p>6 6 8</p> <p>7 7 9</p> <p>8 8 10</p> <p>9 9 11</p>
<p>b.</p> <p>Name of place of employment</p> <p>Address</p> <p>City State ZIP</p>				<p>b.</p> <p>Name of place of employment</p> <p>Address</p> <p>City State ZIP</p>			
<p>4a. Place of employment</p> <p><input type="radio"/> Hospital</p> <p><input type="radio"/> Physician's office</p> <p><input type="radio"/> Other (please specify <input type="checkbox"/>)</p>	<p>c.</p> <p>DOSIMETER</p> <p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>	<p>d. Year began</p> <p>19 <input type="text"/> <input type="text"/></p> <p>0 0</p> <p>1 1</p> <p>2 2</p> <p>3 3</p> <p>4 4</p> <p>5 5</p> <p>6 6</p> <p>7 7</p> <p>8 8</p> <p>9 9</p>	<p>Length of Employment</p> <p>Yrs. Mos.</p> <p><input type="text"/> <input type="text"/> 1</p> <p>0 0 2</p> <p>1 1 3</p> <p>2 2 4</p> <p>3 3 5</p> <p>4 4 6</p> <p>5 5 7</p> <p>6 6 8</p> <p>7 7 9</p> <p>8 8 10</p> <p>9 9 11</p>	<p>8a. Place of employment</p> <p><input type="radio"/> Hospital</p> <p><input type="radio"/> Physician's office</p> <p><input type="radio"/> Other (please specify <input type="checkbox"/>)</p>	<p>c.</p> <p>DOSIMETER</p> <p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p>	<p>d. Year began</p> <p>19 <input type="text"/> <input type="text"/></p> <p>0 0</p> <p>1 1</p> <p>2 2</p> <p>3 3</p> <p>4 4</p> <p>5 5</p> <p>6 6</p> <p>7 7</p> <p>8 8</p> <p>9 9</p>	<p>Length of Employment</p> <p>Yrs. Mos.</p> <p><input type="text"/> <input type="text"/> 1</p> <p>0 0 2</p> <p>1 1 3</p> <p>2 2 4</p> <p>3 3 5</p> <p>4 4 6</p> <p>5 5 7</p> <p>6 6 8</p> <p>7 7 9</p> <p>8 8 10</p> <p>9 9 11</p>
<p>b.</p> <p>Name of place of employment</p> <p>Address</p> <p>City State ZIP</p>				<p>b.</p> <p>Name of place of employment</p> <p>Address</p> <p>City State ZIP</p>			

20. While employed as a radiologic technologist or radiologic technician have you ever worked or assisted with any of the following procedures? Please mark "yes" or "no" for each procedure. For each "yes" fill in the year you began work with that procedure and the length of time in years and months you worked with the procedure. Please include your hospital training program.

IF YOU ARE UNABLE TO PROVIDE THE EXACT YEAR YOU BEGAN WORK WITH THAT PROCEDURE, OR THE LENGTH OF TIME, PLEASE PROVIDE YOUR BEST ESTIMATE.

1-8 Diagnostic

<p>1. Fluoroscopy</p> <p>Ever used? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know</p> <p>Year began: 19 <input type="text"/> <input type="text"/> Total Years Mos.: <input type="text"/> <input type="text"/> (1)</p> <p>0 0 0 0 2 1 1 1 1 3 2 2 2 2 4 3 3 3 3 5 4 4 4 4 6 5 5 5 5 7 6 6 6 6 8 7 7 7 7 9 8 8 8 8 10 9 9 9 9 11</p>	<p>2. Dental X-ray</p> <p>Ever used? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know</p> <p>Year began: 19 <input type="text"/> <input type="text"/> Total Years Mos.: <input type="text"/> <input type="text"/> (1)</p> <p>0 0 0 0 2 1 1 1 1 3 2 2 2 2 4 3 3 3 3 5 4 4 4 4 6 5 5 5 5 7 6 6 6 6 8 7 7 7 7 9 8 8 8 8 10 9 9 9 9 11</p>	<p>3. Routine X-ray other than fluoroscopic film & dental</p> <p>Ever used? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know</p> <p>Year began: 19 <input type="text"/> <input type="text"/> Total Years Mos.: <input type="text"/> <input type="text"/> (1)</p> <p>0 0 0 0 2 1 1 1 1 3 2 2 2 2 4 3 3 3 3 5 4 4 4 4 6 5 5 5 5 7 6 6 6 6 8 7 7 7 7 9 8 8 8 8 10 9 9 9 9 11</p>
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<p>4. Multi-film procedures (e.g. IVP)</p> <p>Ever used? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know</p> <p>Year began: 19 <input type="text"/> <input type="text"/> Total Years Mos.: <input type="text"/> <input type="text"/> (1)</p> <p>0 0 0 0 2 1 1 1 1 3 2 2 2 2 4 3 3 3 3 5 4 4 4 4 6 5 5 5 5 7 6 6 6 6 8 7 7 7 7 9 8 8 8 8 10 9 9 9 9 11</p>	<p>5. CAT Scan</p> <p>Ever used? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know</p> <p>Year began: 19 <input type="text"/> <input type="text"/> Total Years Mos.: <input type="text"/> <input type="text"/> (1)</p> <p>0 0 0 0 2 1 1 1 1 3 2 2 2 2 4 3 3 3 3 5 4 4 4 4 6 5 5 5 5 7 6 6 6 6 8 7 7 7 7 9 8 8 8 8 10 9 9 9 9 11</p>	<p>6. Portable X-ray</p> <p>Number of times <input type="radio"/> Never <input type="radio"/> 1-9 <input type="radio"/> 10-24 <input type="radio"/> 25-49 <input type="radio"/> 50+</p>
---	---	---

7. Diagnostic radioisotopes (e.g. I-131 uptakes)

Ever used?
 Yes No
 Don't know

Year began: 19 Total Years Mos.: (1)

0 0 0 0 2
 1 1 1 1 3
 2 2 2 2 4
 3 3 3 3 5
 4 4 4 4 6
 5 5 5 5 7
 6 6 6 6 8
 7 7 7 7 9
 8 8 8 8 10
 9 9 9 9 11

8. Diagnostic ultrasound

Ever used?
 Yes No
 Don't know

Year began: 19 Total Years Mos.: (1)

0 0 0 0 2
 1 1 1 1 3
 2 2 2 2 4
 3 3 3 3 5
 4 4 4 4 6
 5 5 5 5 7
 6 6 6 6 8
 7 7 7 7 9
 8 8 8 8 10
 9 9 9 9 11

9. Orthovoltage (200-400 kVp)

Ever used?
 Yes No
 Don't know

Year began: 19 Total Years Mos.: (1)

0 0 0 0 2
 1 1 1 1 3
 2 2 2 2 4
 3 3 3 3 5
 4 4 4 4 6
 5 5 5 5 7
 6 6 6 6 8
 7 7 7 7 9
 8 8 8 8 10
 9 9 9 9 11

10. Cobalt 60

Ever used?
 Yes No
 Don't know

Year began: 19 Total Years Mos.: (1)

0 0 0 0 2
 1 1 1 1 3
 2 2 2 2 4
 3 3 3 3 5
 4 4 4 4 6
 5 5 5 5 7
 6 6 6 6 8
 7 7 7 7 9
 8 8 8 8 10
 9 9 9 9 11

11. Betatron

Ever used?
 Yes No
 Don't know

Year began: 19 Total Years Mos.: (1)

0 0 0 0 2
 1 1 1 1 3
 2 2 2 2 4
 3 3 3 3 5
 4 4 4 4 6
 5 5 5 5 7
 6 6 6 6 8
 7 7 7 7 9
 8 8 8 8 10
 9 9 9 9 11

12. Other X-ray teletherapy (LINAC)

Ever used?
 Yes No
 Don't know

Year began: 19 Total Years Mos.: (1)

0 0 0 0 2
 1 1 1 1 3
 2 2 2 2 4
 3 3 3 3 5
 4 4 4 4 6
 5 5 5 5 7
 6 6 6 6 8
 7 7 7 7 9
 8 8 8 8 10
 9 9 9 9 11

13. Radium therapy

Ever used?
 Yes No
 Don't know

Year began: 19 Total Years Mos.: (1)

0 0 0 0 2
 1 1 1 1 3
 2 2 2 2 4
 3 3 3 3 5
 4 4 4 4 6
 5 5 5 5 7
 6 6 6 6 8
 7 7 7 7 9
 8 8 8 8 10
 9 9 9 9 11

14. Other radioisotope therapy

Ever used?
 Yes No
 Don't know

Year began: 19 Total Years Mos.: (1)

0 0 0 0 2
 1 1 1 1 3
 2 2 2 2 4
 3 3 3 3 5
 4 4 4 4 6
 5 5 5 5 7
 6 6 6 6 8
 7 7 7 7 9
 8 8 8 8 10
 9 9 9 9 11

15. Microwave or Ultrasound diathermy

Ever used?
 Yes No
 Don't know

Year began: 19 Total Years Mos.: (1)

0 0 0 0 2
 1 1 1 1 3
 2 2 2 2 4
 3 3 3 3 5
 4 4 4 4 6
 5 5 5 5 7
 6 6 6 6 8
 7 7 7 7 9
 8 8 8 8 10
 9 9 9 9 11

21a. If you wore a dosimetry badge (film badge, TLD, pocket chamber, etc.) where did you usually wear it? (Mark only the one that is used most often.)

- Never wore a dosimeter
- Belt loop, waist or side pocket
- Breast pocket
- Lapel
- Other (describe below _____)

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STAY WITHIN BOX

21b. Did you also usually wear a hand or wrist dosimeter?

- Yes
- No

22. When you were first working as a radiologic technologist or radiologic technician, did you usually wear a lead apron or stand behind a protective shield?

- Yes
- No

IF YOU ARE NOT CURRENTLY WORKING AS A RADIOLOGIC TECHNOLOGIST OR RADIOLOGIC TECHNICIAN, SKIP TO QUESTION 25.

23. Do you usually wear a lead apron or stand behind a shield now?

- Yes
- No

IF YOU MARKED NO, SKIP TO QUESTION 25.

24. When you wear an apron, where do you usually wear your dosimetry badge?

- Don't usually wear a badge.
 - Under the apron
 - Outside the apron
 - Varies, sometimes under sometimes outside
 - Badge is not worn but is located in X-ray room
- (Describe below _____)

25. Were you ever employed in a position other than as a radiologic technologist or radiologic technician for more than one year?

- Yes
- No

IF YOU MARKED NO, SKIP TO QUESTION 28.

26. Other than as a radiologic technologist or radiologic technician, what was the occupation or job in which you were employed for the longest time? (please specify _____)

NAME OF OCCUPATION

27. In what year did you first work in a position other than as a radiologic technologist or radiologic technician?

19		
	0	0
	1	1
	2	2
	3	3
	4	4
	5	5
	6	6
	7	7
	8	8
	9	9

27a. Altogether, approximately how many years did you work in a position or positions other than as a radiologic technologist or radiologic technician?

			YEARS
	0	0	
	1	1	
	2	2	
	3	3	
	4	4	
	5	5	
	6	6	
	7	7	
	8	8	
	9	9	

28. Approximately how many times have you held a person for an X-ray?

- Never
- 25-49 times
- 1-9 times
- 50+ times
- 10-24 times

II. MEDICAL HISTORY

29. Have you ever been told by a doctor that you had a thyroid condition, for example, thyroid nodules, thyroid cancer, hyperthyroidism, hypothyroidism, goiter, etc.?

Yes No Don't know

IF YOU MARKED NO OR DON'T KNOW, SKIP TO QUESTION 33.

30. What was the specific medical name for the thyroid condition(s)? (Mark all that apply)

Hyperthyroidism Thyroid cancer
 Hypothyroidism Goiter
 Thyroiditis Other (please specify)

PLEASE PRINT — STAY WITHIN BOX

Don't know exact medical name

31. When was the thyroid condition first diagnosed?

	YEAR																					
	19	<table border="1" style="border-collapse: collapse; width: 30px; height: 60px; margin: 0 auto;"> <tr><td>0</td><td>0</td></tr> <tr><td>1</td><td>1</td></tr> <tr><td>2</td><td>2</td></tr> <tr><td>3</td><td>3</td></tr> <tr><td>4</td><td>4</td></tr> <tr><td>5</td><td>5</td></tr> <tr><td>6</td><td>6</td></tr> <tr><td>7</td><td>7</td></tr> <tr><td>8</td><td>8</td></tr> <tr><td>9</td><td>9</td></tr> </table>	0	0	1	1	2	2	3	3	4	4	5	5	6	6	7	7	8	8	9	9
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32. What was the name and address of the doctor or hospital that diagnosed the thyroid condition?

Name: _____

Address: _____
Street

City _____ State _____ ZIP _____

33. Have you ever been told by a doctor that you had leukemia, Hodgkin's disease, multiple myeloma, or any other type of cancer?

Yes No Don't know

IF YOU MARKED NO, SKIP TO QUESTION 35.

34. Please fill in the information asked below for each type of cancer you had.

- (a) What was the type of cancer?
 (b) In what month and year did the doctor tell you about the cancer?
 (c) What was the name and address of the doctor or hospital that first treated you for this cancer?
 (Space is provided for up to 3 cancer types.)

<p>a. Type of cancer (Mark only one)</p> <p> <input type="radio"/> Lung <input type="radio"/> Multiple <input type="radio"/> Cervix <input type="radio"/> Stomach Myeloma <input type="radio"/> Uterus <input type="radio"/> Colon <input type="radio"/> Skin <input type="radio"/> Ovary <input type="radio"/> Rectum <input type="radio"/> Prostate <input type="radio"/> Other (please specify the site of the cancer) <input type="radio"/> Leukemia <input type="radio"/> Breast <input type="radio"/> Hodgkin's disease </p> <div style="border: 1px solid black; width: 150px; height: 30px; margin-left: 100px; margin-top: 10px;"></div>	<p>b. Date when diagnosed</p> <p style="text-align: center;">Mo. Year</p> <p>Jan <input type="radio"/> <input type="radio"/></p> <p>Feb <input type="radio"/> <input type="radio"/></p> <p>Mar <input type="radio"/> <input type="radio"/></p> <p>Apr <input type="radio"/> <input type="radio"/></p> <p>May <input type="radio"/> <input type="radio"/></p> <p>Jun <input type="radio"/> <input type="radio"/></p> <p>Jul <input type="radio"/> <input type="radio"/></p> <p>Aug <input type="radio"/> <input type="radio"/></p> <p>Sep <input type="radio"/> <input type="radio"/></p> <p>Oct <input type="radio"/> <input type="radio"/></p> <p>Nov <input type="radio"/> <input type="radio"/></p> <p>Dec <input type="radio"/> <input type="radio"/></p>
<p>c. _____ <small style="margin-left: 100px;">Name of doctor or hospital</small></p> <p>d. _____ <small style="margin-left: 100px;">Street</small></p> <p>City _____ State _____ ZIP _____</p>	

<p>a. Type of cancer (Mark only one)</p> <p> <input type="radio"/> Lung <input type="radio"/> Multiple <input type="radio"/> Cervix <input type="radio"/> Stomach Myeloma <input type="radio"/> Uterus <input type="radio"/> Colon <input type="radio"/> Skin <input type="radio"/> Ovary <input type="radio"/> Rectum <input type="radio"/> Prostate <input type="radio"/> Other (please specify the site of the cancer) <input type="radio"/> Leukemia <input type="radio"/> Breast <input type="radio"/> Hodgkin's disease </p> <div style="border: 1px solid black; width: 150px; height: 30px; margin-left: 100px; margin-top: 10px;"></div>	<p>b. Date when diagnosed</p> <p style="text-align: center;">Mo. Year</p> <p>Jan <input type="radio"/> <input type="radio"/></p> <p>Feb <input type="radio"/> <input type="radio"/></p> <p>Mar <input type="radio"/> <input type="radio"/></p> <p>Apr <input type="radio"/> <input type="radio"/></p> <p>May <input type="radio"/> <input type="radio"/></p> <p>Jun <input type="radio"/> <input type="radio"/></p> <p>Jul <input type="radio"/> <input type="radio"/></p> <p>Aug <input type="radio"/> <input type="radio"/></p> <p>Sep <input type="radio"/> <input type="radio"/></p> <p>Oct <input type="radio"/> <input type="radio"/></p> <p>Nov <input type="radio"/> <input type="radio"/></p> <p>Dec <input type="radio"/> <input type="radio"/></p>
<p>c. _____ <small style="margin-left: 100px;">Name of doctor or hospital</small></p> <p>d. _____ <small style="margin-left: 100px;">Street</small></p> <p>City _____ State _____ ZIP _____</p>	

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<p>c. _____ <small style="margin-left: 100px;">Name of doctor or hospital</small></p> <p>d. _____ <small style="margin-left: 100px;">Street</small></p> <p>City _____ State _____ ZIP _____</p>	

35. Have you ever been told by a doctor that you have had a myocardial infarction (heart attack)?

- Yes
 No
 Don't know

IF YOU MARKED NO, SKIP TO QUESTION 37.

36. How old were you the first time you had a myocardial infarction?

AGE

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

37. Have you ever had any children? (Please only include children born live. Don't include adopted or foster children.)

- Yes
 No

IF YOU MARKED NO, SKIP TO QUESTION 43 NEXT.

38. What is the date of birth of your first child?

MONTH	DAY	YEAR
JAN <input type="radio"/>		19
FEB <input type="radio"/>		
MAR <input type="radio"/>	0 0	0 0
APR <input type="radio"/>	1 1	1 1
MAY <input type="radio"/>	2 2	2 2
JUN <input type="radio"/>	3 3	3 3
JUL <input type="radio"/>	4 4	4 4
AUG <input type="radio"/>	5 5	5 5
SEP <input type="radio"/>	6 6	6 6
OCT <input type="radio"/>	7 7	7 7
NOV <input type="radio"/>	8 8	8 8
DEC <input type="radio"/>	9 9	9 9

39. Were any of your children born with a birth defect?

- Yes
 No

IF YOU MARKED NO, SKIP TO QUESTION 41

40. Please complete the following information about each child born to you with a birth defect. (a) Date of birth (b) Sex (c) Nature of birth defect(s) (d) Hospital where diagnosed

Child 1

a. Date of birth	Year	b. Sex	<input type="radio"/> Male	<input type="radio"/> Female
Month	19	c. Nature of defect(s)		
JAN <input type="radio"/>		<div style="border: 1px solid black; height: 30px; width: 100%;"></div>		
FEB <input type="radio"/>	0 0			
MAR <input type="radio"/>	1 1			
APR <input type="radio"/>	2 2			
MAY <input type="radio"/>	3 3			
JUN <input type="radio"/>	4 4			
JUL <input type="radio"/>	5 5			
AUG <input type="radio"/>	6 6			
SEP <input type="radio"/>	7 7			
OCT <input type="radio"/>	8 8			
NOV <input type="radio"/>	9 9			
DEC <input type="radio"/>				
d. Hospital where diagnosed		<div style="border: 1px solid black; height: 40px; width: 100%;"></div>		
		Name of hospital		
		Street		
		City State ZIP		

Child 2

a. Date of birth	Year	b. Sex	<input type="radio"/> Male	<input type="radio"/> Female
Month	19	c. Nature of defect(s)		
JAN <input type="radio"/>		<div style="border: 1px solid black; height: 30px; width: 100%;"></div>		
FEB <input type="radio"/>	0 0			
MAR <input type="radio"/>	1 1			
APR <input type="radio"/>	2 2			
MAY <input type="radio"/>	3 3			
JUN <input type="radio"/>	4 4			
JUL <input type="radio"/>	5 5			
AUG <input type="radio"/>	6 6			
SEP <input type="radio"/>	7 7			
OCT <input type="radio"/>	8 8			
NOV <input type="radio"/>	9 9			
DEC <input type="radio"/>				
d. Hospital where diagnosed		<div style="border: 1px solid black; height: 40px; width: 100%;"></div>		
		Name of hospital		
		Street		
		City State ZIP		

Child 3

a. Date of birth	Year	b. Sex	<input type="radio"/> Male	<input type="radio"/> Female
Month	19	c. Nature of defect(s)		
JAN <input type="radio"/>		<div style="border: 1px solid black; height: 30px; width: 100%;"></div>		
FEB <input type="radio"/>	0 0			
MAR <input type="radio"/>	1 1			
APR <input type="radio"/>	2 2			
MAY <input type="radio"/>	3 3			
JUN <input type="radio"/>	4 4			
JUL <input type="radio"/>	5 5			
AUG <input type="radio"/>	6 6			
SEP <input type="radio"/>	7 7			
OCT <input type="radio"/>	8 8			
NOV <input type="radio"/>	9 9			
DEC <input type="radio"/>				
d. Hospital where diagnosed		<div style="border: 1px solid black; height: 40px; width: 100%;"></div>		
		Name of hospital		
		Street		
		City State ZIP		

41. Have any of your children died?

Yes No

IF YOU MARKED NO, SKIP TO QUESTION 43.

42. Complete the following information about each child that died. (a) Sex (b) Date of birth (c) Date of death and (d) Cause of death.

Child 1 a. Sex: Male Female

b. Date of birth c. Date of death d. Cause of death (please specify)

MONTH	YEAR	MONTH	YEAR	PLEASE WRITE IN BOX ONLY
<input type="radio"/> Jan	19 <input type="text"/> <input type="text"/>	<input type="radio"/> Jan	19 <input type="text"/> <input type="text"/>	
<input type="radio"/> Feb	<input type="text"/> <input type="text"/>	<input type="radio"/> Feb	<input type="text"/> <input type="text"/>	
<input type="radio"/> Mar	<input type="text"/> <input type="text"/>	<input type="radio"/> Mar	<input type="text"/> <input type="text"/>	
<input type="radio"/> Apr	<input type="text"/> <input type="text"/>	<input type="radio"/> Apr	<input type="text"/> <input type="text"/>	
<input type="radio"/> May	<input type="text"/> <input type="text"/>	<input type="radio"/> May	<input type="text"/> <input type="text"/>	
<input type="radio"/> Jun	<input type="text"/> <input type="text"/>	<input type="radio"/> Jun	<input type="text"/> <input type="text"/>	
<input type="radio"/> Jul	<input type="text"/> <input type="text"/>	<input type="radio"/> Jul	<input type="text"/> <input type="text"/>	
<input type="radio"/> Aug	<input type="text"/> <input type="text"/>	<input type="radio"/> Aug	<input type="text"/> <input type="text"/>	
<input type="radio"/> Sep	<input type="text"/> <input type="text"/>	<input type="radio"/> Sep	<input type="text"/> <input type="text"/>	
<input type="radio"/> Oct	<input type="text"/> <input type="text"/>	<input type="radio"/> Oct	<input type="text"/> <input type="text"/>	
<input type="radio"/> Nov	<input type="text"/> <input type="text"/>	<input type="radio"/> Nov	<input type="text"/> <input type="text"/>	
<input type="radio"/> Dec	<input type="text"/> <input type="text"/>	<input type="radio"/> Dec	<input type="text"/> <input type="text"/>	

Child 2 a. Sex Male Female

b. Date of birth c. Date of death d. Cause of death (please specify)

MONTH	YEAR	MONTH	YEAR	PLEASE WRITE IN BOX ONLY
<input type="radio"/> Jan	19 <input type="text"/> <input type="text"/>	<input type="radio"/> Jan	19 <input type="text"/> <input type="text"/>	
<input type="radio"/> Feb	<input type="text"/> <input type="text"/>	<input type="radio"/> Feb	<input type="text"/> <input type="text"/>	
<input type="radio"/> Mar	<input type="text"/> <input type="text"/>	<input type="radio"/> Mar	<input type="text"/> <input type="text"/>	
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<input type="radio"/> Nov	<input type="text"/> <input type="text"/>	<input type="radio"/> Nov	<input type="text"/> <input type="text"/>	
<input type="radio"/> Dec	<input type="text"/> <input type="text"/>	<input type="radio"/> Dec	<input type="text"/> <input type="text"/>	

Child 3 a. Sex Male Female

b. Date of birth c. Date of death d. Cause of death (please specify)

MONTH	YEAR	MONTH	YEAR	PLEASE WRITE IN BOX ONLY
<input type="radio"/> Jan	19 <input type="text"/> <input type="text"/>	<input type="radio"/> Jan	19 <input type="text"/> <input type="text"/>	
<input type="radio"/> Feb	<input type="text"/> <input type="text"/>	<input type="radio"/> Feb	<input type="text"/> <input type="text"/>	
<input type="radio"/> Mar	<input type="text"/> <input type="text"/>	<input type="radio"/> Mar	<input type="text"/> <input type="text"/>	
<input type="radio"/> Apr	<input type="text"/> <input type="text"/>	<input type="radio"/> Apr	<input type="text"/> <input type="text"/>	
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43. For each of the following SPECIAL X-RAY PROCEDURES, APPROXIMATE (a) whether you ever had the procedure. For each procedure you had, APPROXIMATE (b) the number of times you had the procedure, and (c) the year you had the procedure for the first time.

<p>1. Have you ever had a Barium Enema?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know</p> <p>Approximate No. of times Approximate Yr. first done</p> <table border="0"> <tr><td><input type="text"/></td><td>19 <input type="text"/></td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> </table>	<input type="text"/>	19 <input type="text"/>	<p>2. Have you ever had a Cholecystogram or a Cholangiogram?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know</p> <p>Approximate No. of times Approximate Yr. first done</p> <table border="0"> <tr><td><input type="text"/></td><td>19 <input type="text"/></td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> </table>	<input type="text"/>	19 <input type="text"/>	<input type="text"/>																																																							
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<p>3. Have you ever had an Intravenous or Retrograde Pyelogram?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know</p> <p>Approximate No. of times Approximate Yr. first done</p> <table border="0"> <tr><td><input type="text"/></td><td>19 <input type="text"/></td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> </table>	<input type="text"/>	19 <input type="text"/>	<p>4. Have you ever had a Renal Arteriogram?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know</p> <p>Approximate No. of times Approximate Yr. first done</p> <table border="0"> <tr><td><input type="text"/></td><td>19 <input type="text"/></td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> </table>	<input type="text"/>	19 <input type="text"/>	<input type="text"/>																																																							
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<p>5. Have you ever had a Kidney, Ureter, Bladder (KUB) X-ray?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know</p> <p>Approximate No. of times Approximate Yr. first done</p> <table border="0"> <tr><td><input type="text"/></td><td>19 <input type="text"/></td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> </table>	<input type="text"/>	19 <input type="text"/>	<p>6. Have you ever had a Urethrogram?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know</p> <p>Approximate No. of times Approximate Yr. first done</p> <table border="0"> <tr><td><input type="text"/></td><td>19 <input type="text"/></td></tr> <tr><td><input type="text"/></td><td><input type="text"/></td></tr> </table>	<input type="text"/>	19 <input type="text"/>	<input type="text"/>																																																							
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44a. We are also interested in **DIAGNOSTIC X-RAYS** you have had, other than those special X-rays listed previously. Please indicate whether or not each part of the body listed has ever been x-rayed. For each "Yes" you mark, please indicate (b) the **APPROXIMATE** number of times you had that part of the body x-rayed and (c) the **APPROXIMATE** year you first had that part of your body x-rayed.

7. Have you ever undergone Cystography?

Yes No Don't Know

Approximate No. of times: 19

Approximate Yr. first done:

0 0 1 1 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9

8. Have you ever had an Upper Gastro-Intestinal Tract series?

Yes No Don't Know

Approximate No. of times: 19

Approximate Yr. first done:

0 0 1 1 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9

9. Have you ever had a Barium Swallow?

Yes No Don't Know

Approximate No. of times: 19

Approximate Yr. first done:

0 0 1 1 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9

10. Have you ever had a Mammogram of the Breast?

Yes No Don't Know

Approximate No. of times: 19

Approximate Yr. first done:

0 0 1 1 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9

11. Have you ever undergone Angiography?

Yes No Don't Know

Approximate No. of times: 19

Approximate Yr. first done:

0 0 1 1 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9

12. Other special X-ray procedures (please specify)

Approximate No. of times: 19

Approximate Yr. first done:

0 0 1 1 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9

Part of body — Head and Neck

1. Skull — ever x-rayed?

Yes No Don't Know

Approximate No. of times: 19

Approximate Yr. first done:

0 0 1 1 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9

2. Dental — ever x-rayed?

Yes No Don't Know

Approximate No. of times: 19

Approximate Yr. first done:

0 0 1 1 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9

3. Cervical spine — ever x-rayed?

Yes No Don't Know

Approximate No. of times: 19

Approximate Yr. first done:

0 0 1 1 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9

4. Other head and neck — ever x-rayed?

Yes No Don't Know

Approximate No. of times: 19

Approximate Yr. first done:

0 0 1 1 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9

Part of body — Trunk

5. Chest — ever x-rayed?

Yes No Don't Know

Approximate No. of times: 19

Approximate Yr. first done:

0 0 1 1 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9

6. Collar bone — ever x-rayed?

Yes No Don't Know

Approximate No. of times: 19

Approximate Yr. first done:

0 0 1 1 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9

<p>7. Shoulder — ever x-rayed?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know</p> <p>Approximate No. of times Approximate Yr. first done</p> <table style="width:100%; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="width: 20px; text-align: center;">19</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr><td style="text-align: center;">0</td><td style="text-align: center;">0</td><td></td><td style="text-align: center;">0</td><td style="text-align: center;">0</td></tr> <tr><td style="text-align: center;">1</td><td style="text-align: center;">1</td><td></td><td style="text-align: center;">1</td><td style="text-align: center;">1</td></tr> <tr><td style="text-align: center;">2</td><td style="text-align: center;">2</td><td></td><td style="text-align: center;">2</td><td style="text-align: center;">2</td></tr> <tr><td style="text-align: center;">3</td><td style="text-align: center;">3</td><td></td><td style="text-align: center;">3</td><td style="text-align: center;">3</td></tr> <tr><td style="text-align: center;">4</td><td style="text-align: center;">4</td><td></td><td style="text-align: center;">4</td><td style="text-align: center;">4</td></tr> <tr><td style="text-align: center;">5</td><td style="text-align: center;">5</td><td></td><td style="text-align: center;">5</td><td style="text-align: center;">5</td></tr> <tr><td style="text-align: center;">6</td><td style="text-align: center;">6</td><td></td><td style="text-align: center;">6</td><td style="text-align: center;">6</td></tr> <tr><td style="text-align: center;">7</td><td style="text-align: center;">7</td><td></td><td style="text-align: center;">7</td><td style="text-align: center;">7</td></tr> <tr><td style="text-align: center;">8</td><td style="text-align: center;">8</td><td></td><td style="text-align: center;">8</td><td style="text-align: center;">8</td></tr> <tr><td style="text-align: center;">9</td><td style="text-align: center;">9</td><td></td><td style="text-align: center;">9</td><td style="text-align: center;">9</td></tr> </table>			19			0	0		0	0	1	1		1	1	2	2		2	2	3	3		3	3	4	4		4	4	5	5		5	5	6	6		6	6	7	7		7	7	8	8		8	8	9	9		9	9	<p>8. Ribs — ever x-rayed?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know</p> <p>Approximate No. of times Approximate Yr. first done</p> <table style="width:100%; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="width: 20px; text-align: center;">19</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr><td style="text-align: center;">0</td><td style="text-align: center;">0</td><td></td><td style="text-align: center;">0</td><td style="text-align: center;">0</td></tr> <tr><td style="text-align: center;">1</td><td style="text-align: center;">1</td><td></td><td style="text-align: center;">1</td><td style="text-align: center;">1</td></tr> <tr><td style="text-align: center;">2</td><td style="text-align: center;">2</td><td></td><td style="text-align: center;">2</td><td style="text-align: center;">2</td></tr> <tr><td style="text-align: center;">3</td><td style="text-align: center;">3</td><td></td><td style="text-align: center;">3</td><td style="text-align: center;">3</td></tr> <tr><td style="text-align: center;">4</td><td style="text-align: center;">4</td><td></td><td style="text-align: center;">4</td><td style="text-align: center;">4</td></tr> <tr><td style="text-align: center;">5</td><td style="text-align: center;">5</td><td></td><td style="text-align: center;">5</td><td style="text-align: center;">5</td></tr> <tr><td style="text-align: center;">6</td><td style="text-align: center;">6</td><td></td><td style="text-align: center;">6</td><td style="text-align: center;">6</td></tr> <tr><td style="text-align: center;">7</td><td style="text-align: center;">7</td><td></td><td style="text-align: center;">7</td><td style="text-align: center;">7</td></tr> <tr><td style="text-align: center;">8</td><td style="text-align: center;">8</td><td></td><td style="text-align: center;">8</td><td style="text-align: center;">8</td></tr> <tr><td style="text-align: center;">9</td><td style="text-align: center;">9</td><td></td><td style="text-align: center;">9</td><td style="text-align: center;">9</td></tr> </table>			19			0	0		0	0	1	1		1	1	2	2		2	2	3	3		3	3	4	4		4	4	5	5		5	5	6	6		6	6	7	7		7	7	8	8		8	8	9	9		9	9	<p>13. Pelvis — ever x-rayed?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know</p> <p>Approximate No. of times Approximate Yr. first done</p> <table style="width:100%; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="width: 20px; text-align: center;">19</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr><td style="text-align: center;">0</td><td style="text-align: center;">0</td><td></td><td style="text-align: center;">0</td><td style="text-align: center;">0</td></tr> <tr><td style="text-align: center;">1</td><td style="text-align: center;">1</td><td></td><td style="text-align: center;">1</td><td style="text-align: center;">1</td></tr> <tr><td style="text-align: center;">2</td><td style="text-align: center;">2</td><td></td><td style="text-align: center;">2</td><td style="text-align: center;">2</td></tr> <tr><td style="text-align: center;">3</td><td style="text-align: center;">3</td><td></td><td style="text-align: center;">3</td><td style="text-align: center;">3</td></tr> <tr><td style="text-align: center;">4</td><td style="text-align: center;">4</td><td></td><td style="text-align: center;">4</td><td style="text-align: center;">4</td></tr> <tr><td style="text-align: center;">5</td><td style="text-align: center;">5</td><td></td><td style="text-align: center;">5</td><td style="text-align: center;">5</td></tr> <tr><td style="text-align: center;">6</td><td style="text-align: center;">6</td><td></td><td style="text-align: center;">6</td><td style="text-align: center;">6</td></tr> <tr><td style="text-align: center;">7</td><td style="text-align: center;">7</td><td></td><td style="text-align: center;">7</td><td style="text-align: center;">7</td></tr> <tr><td style="text-align: center;">8</td><td style="text-align: center;">8</td><td></td><td style="text-align: center;">8</td><td style="text-align: center;">8</td></tr> <tr><td style="text-align: center;">9</td><td style="text-align: center;">9</td><td></td><td style="text-align: center;">9</td><td style="text-align: center;">9</td></tr> </table>			19			0	0		0	0	1	1		1	1	2	2		2	2	3	3		3	3	4	4		4	4	5	5		5	5	6	6		6	6	7	7		7	7	8	8		8	8	9	9		9	9	<p>14. 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<p>9. Abdomen — ever x-rayed?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know</p> <p>Approximate No. of times Approximate Yr. first done</p> <table style="width:100%; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="width: 20px; text-align: center;">19</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr><td style="text-align: center;">0</td><td style="text-align: center;">0</td><td></td><td style="text-align: center;">0</td><td style="text-align: center;">0</td></tr> <tr><td style="text-align: center;">1</td><td style="text-align: center;">1</td><td></td><td style="text-align: center;">1</td><td style="text-align: center;">1</td></tr> <tr><td style="text-align: center;">2</td><td style="text-align: center;">2</td><td></td><td style="text-align: center;">2</td><td style="text-align: center;">2</td></tr> <tr><td style="text-align: center;">3</td><td style="text-align: center;">3</td><td></td><td style="text-align: center;">3</td><td style="text-align: center;">3</td></tr> <tr><td style="text-align: center;">4</td><td style="text-align: center;">4</td><td></td><td style="text-align: center;">4</td><td style="text-align: center;">4</td></tr> <tr><td style="text-align: center;">5</td><td style="text-align: center;">5</td><td></td><td style="text-align: center;">5</td><td style="text-align: center;">5</td></tr> <tr><td style="text-align: center;">6</td><td style="text-align: center;">6</td><td></td><td style="text-align: center;">6</td><td style="text-align: center;">6</td></tr> <tr><td style="text-align: center;">7</td><td style="text-align: center;">7</td><td></td><td style="text-align: center;">7</td><td style="text-align: center;">7</td></tr> <tr><td style="text-align: center;">8</td><td style="text-align: center;">8</td><td></td><td style="text-align: center;">8</td><td style="text-align: center;">8</td></tr> <tr><td style="text-align: center;">9</td><td style="text-align: center;">9</td><td></td><td style="text-align: center;">9</td><td style="text-align: center;">9</td></tr> </table>			19			0	0		0	0	1	1		1	1	2	2		2	2	3	3		3	3	4	4		4	4	5	5		5	5	6	6		6	6	7	7		7	7	8	8		8	8	9	9		9	9	<p>10. Thoracic spine — ever x-rayed?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know</p> <p>Approximate No. of times Approximate Yr. first done</p> <table style="width:100%; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="width: 20px; text-align: center;">19</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr><td style="text-align: center;">0</td><td style="text-align: center;">0</td><td></td><td style="text-align: center;">0</td><td style="text-align: center;">0</td></tr> <tr><td style="text-align: center;">1</td><td style="text-align: center;">1</td><td></td><td style="text-align: center;">1</td><td style="text-align: center;">1</td></tr> <tr><td style="text-align: center;">2</td><td style="text-align: center;">2</td><td></td><td style="text-align: center;">2</td><td style="text-align: center;">2</td></tr> <tr><td style="text-align: center;">3</td><td style="text-align: center;">3</td><td></td><td style="text-align: center;">3</td><td style="text-align: center;">3</td></tr> <tr><td style="text-align: center;">4</td><td style="text-align: center;">4</td><td></td><td style="text-align: center;">4</td><td style="text-align: center;">4</td></tr> <tr><td style="text-align: center;">5</td><td style="text-align: center;">5</td><td></td><td style="text-align: center;">5</td><td style="text-align: center;">5</td></tr> <tr><td style="text-align: center;">6</td><td style="text-align: center;">6</td><td></td><td style="text-align: center;">6</td><td style="text-align: center;">6</td></tr> <tr><td style="text-align: center;">7</td><td style="text-align: center;">7</td><td></td><td style="text-align: center;">7</td><td style="text-align: center;">7</td></tr> <tr><td style="text-align: center;">8</td><td style="text-align: center;">8</td><td></td><td style="text-align: center;">8</td><td style="text-align: center;">8</td></tr> <tr><td style="text-align: center;">9</td><td style="text-align: center;">9</td><td></td><td style="text-align: center;">9</td><td style="text-align: center;">9</td></tr> </table>			19			0	0		0	0	1	1		1	1	2	2		2	2	3	3		3	3	4	4		4	4	5	5		5	5	6	6		6	6	7	7		7	7	8	8		8	8	9	9		9	9
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44b. Have you ever personally undergone any THERAPEUTIC X-RAY PROCEDURES? Here we are interested in procedures performed on you, not those performed by you.

Yes
 No
 Don't Know

IF YOU MARKED NO OR DON'T KNOW, SKIP TO QUESTION 45.

If you marked yes, please mark the body site(s) treated with X-rays and the year treated, and list the reasons for the therapy on page 12.

<p>11. Lumbar spine — ever x-rayed?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know</p> <p>Approximate No. of times Approximate Yr. first done</p> <table style="width:100%; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="width: 20px; text-align: center;">19</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr><td style="text-align: center;">0</td><td style="text-align: center;">0</td><td></td><td style="text-align: center;">0</td><td style="text-align: center;">0</td></tr> <tr><td style="text-align: center;">1</td><td style="text-align: center;">1</td><td></td><td style="text-align: center;">1</td><td style="text-align: center;">1</td></tr> <tr><td style="text-align: center;">2</td><td style="text-align: center;">2</td><td></td><td style="text-align: center;">2</td><td style="text-align: center;">2</td></tr> <tr><td style="text-align: center;">3</td><td style="text-align: center;">3</td><td></td><td style="text-align: center;">3</td><td style="text-align: center;">3</td></tr> <tr><td style="text-align: center;">4</td><td style="text-align: center;">4</td><td></td><td style="text-align: center;">4</td><td style="text-align: center;">4</td></tr> <tr><td style="text-align: center;">5</td><td style="text-align: center;">5</td><td></td><td style="text-align: center;">5</td><td style="text-align: center;">5</td></tr> <tr><td style="text-align: center;">6</td><td style="text-align: center;">6</td><td></td><td style="text-align: center;">6</td><td style="text-align: center;">6</td></tr> <tr><td style="text-align: center;">7</td><td style="text-align: center;">7</td><td></td><td style="text-align: center;">7</td><td style="text-align: center;">7</td></tr> <tr><td style="text-align: center;">8</td><td style="text-align: center;">8</td><td></td><td style="text-align: center;">8</td><td style="text-align: center;">8</td></tr> <tr><td style="text-align: center;">9</td><td style="text-align: center;">9</td><td></td><td style="text-align: center;">9</td><td style="text-align: center;">9</td></tr> </table>			19			0	0		0	0	1	1		1	1	2	2		2	2	3	3		3	3	4	4		4	4	5	5		5	5	6	6		6	6	7	7		7	7	8	8		8	8	9	9		9	9	<p>12. Lumbosacral spine — ever x-rayed?</p> <p><input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't Know</p> <p>Approximate No. of times Approximate Yr. first done</p> <table style="width:100%; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="width: 20px; text-align: center;">19</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr><td style="text-align: center;">0</td><td style="text-align: center;">0</td><td></td><td style="text-align: center;">0</td><td style="text-align: center;">0</td></tr> <tr><td style="text-align: center;">1</td><td style="text-align: center;">1</td><td></td><td style="text-align: center;">1</td><td style="text-align: center;">1</td></tr> <tr><td style="text-align: center;">2</td><td style="text-align: center;">2</td><td></td><td style="text-align: center;">2</td><td style="text-align: center;">2</td></tr> <tr><td style="text-align: center;">3</td><td style="text-align: center;">3</td><td></td><td style="text-align: center;">3</td><td style="text-align: center;">3</td></tr> <tr><td style="text-align: center;">4</td><td style="text-align: center;">4</td><td></td><td style="text-align: center;">4</td><td style="text-align: center;">4</td></tr> <tr><td style="text-align: center;">5</td><td style="text-align: center;">5</td><td></td><td style="text-align: center;">5</td><td style="text-align: center;">5</td></tr> <tr><td style="text-align: center;">6</td><td style="text-align: center;">6</td><td></td><td style="text-align: center;">6</td><td style="text-align: center;">6</td></tr> <tr><td style="text-align: center;">7</td><td style="text-align: center;">7</td><td></td><td style="text-align: center;">7</td><td style="text-align: center;">7</td></tr> <tr><td style="text-align: center;">8</td><td style="text-align: center;">8</td><td></td><td style="text-align: center;">8</td><td style="text-align: center;">8</td></tr> <tr><td style="text-align: center;">9</td><td style="text-align: center;">9</td><td></td><td style="text-align: center;">9</td><td style="text-align: center;">9</td></tr> </table>			19			0	0		0	0	1	1		1	1	2	2		2	2	3	3		3	3	4	4		4	4	5	5		5	5	6	6		6	6	7	7		7	7	8	8		8	8	9	9		9	9
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<p>1. Head and neck</p> <p>Year first treated</p> <table style="width:100%; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="width: 20px; text-align: center;">19</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr><td style="text-align: center;">0</td><td style="text-align: center;">0</td><td></td><td style="text-align: center;">0</td><td style="text-align: center;">0</td></tr> <tr><td style="text-align: center;">1</td><td style="text-align: center;">1</td><td></td><td style="text-align: center;">1</td><td style="text-align: center;">1</td></tr> <tr><td style="text-align: center;">2</td><td style="text-align: center;">2</td><td></td><td style="text-align: center;">2</td><td style="text-align: center;">2</td></tr> <tr><td style="text-align: center;">3</td><td style="text-align: center;">3</td><td></td><td style="text-align: center;">3</td><td style="text-align: center;">3</td></tr> <tr><td style="text-align: center;">4</td><td style="text-align: center;">4</td><td></td><td style="text-align: center;">4</td><td style="text-align: center;">4</td></tr> <tr><td style="text-align: center;">5</td><td style="text-align: center;">5</td><td></td><td style="text-align: center;">5</td><td style="text-align: center;">5</td></tr> <tr><td style="text-align: center;">6</td><td style="text-align: center;">6</td><td></td><td style="text-align: center;">6</td><td style="text-align: center;">6</td></tr> <tr><td style="text-align: center;">7</td><td style="text-align: center;">7</td><td></td><td style="text-align: center;">7</td><td style="text-align: center;">7</td></tr> <tr><td style="text-align: center;">8</td><td style="text-align: center;">8</td><td></td><td style="text-align: center;">8</td><td style="text-align: center;">8</td></tr> <tr><td style="text-align: center;">9</td><td style="text-align: center;">9</td><td></td><td style="text-align: center;">9</td><td style="text-align: center;">9</td></tr> </table>			19			0	0		0	0	1	1		1	1	2	2		2	2	3	3		3	3	4	4		4	4	5	5		5	5	6	6		6	6	7	7		7	7	8	8		8	8	9	9		9	9	<p>2. Pelvis</p> <p>Year first treated</p> <table style="width:100%; border: none;"> <tr> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="width: 20px; text-align: center;">19</td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> <td style="border: 1px solid black; width: 20px; height: 20px;"></td> </tr> <tr><td style="text-align: center;">0</td><td style="text-align: center;">0</td><td></td><td style="text-align: center;">0</td><td style="text-align: center;">0</td></tr> <tr><td style="text-align: center;">1</td><td style="text-align: center;">1</td><td></td><td style="text-align: center;">1</td><td style="text-align: center;">1</td></tr> <tr><td style="text-align: center;">2</td><td style="text-align: center;">2</td><td></td><td style="text-align: center;">2</td><td style="text-align: center;">2</td></tr> <tr><td style="text-align: center;">3</td><td style="text-align: center;">3</td><td></td><td style="text-align: center;">3</td><td style="text-align: center;">3</td></tr> <tr><td style="text-align: center;">4</td><td style="text-align: center;">4</td><td></td><td style="text-align: center;">4</td><td style="text-align: center;">4</td></tr> <tr><td style="text-align: center;">5</td><td style="text-align: center;">5</td><td></td><td style="text-align: center;">5</td><td style="text-align: center;">5</td></tr> <tr><td style="text-align: center;">6</td><td style="text-align: center;">6</td><td></td><td style="text-align: center;">6</td><td style="text-align: center;">6</td></tr> <tr><td style="text-align: center;">7</td><td style="text-align: center;">7</td><td></td><td style="text-align: center;">7</td><td style="text-align: center;">7</td></tr> <tr><td style="text-align: center;">8</td><td style="text-align: center;">8</td><td></td><td style="text-align: center;">8</td><td style="text-align: center;">8</td></tr> <tr><td style="text-align: center;">9</td><td style="text-align: center;">9</td><td></td><td style="text-align: center;">9</td><td style="text-align: center;">9</td></tr> </table>			19			0	0		0	0	1	1		1	1	2	2		2	2	3	3		3	3	4	4		4	4	5	5		5	5	6	6		6	6	7	7		7	7	8	8		8	8	9	9		9	9
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44b. (Continued) Continue to mark the body site(s) treated with X-rays and the year treated.

3. Extremities

Year first treated

19

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9

4. Chest

Year first treated

19

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9

5. Other body sites
(please specify sites →)

Please Print — Stay within box

Year first treated

19

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9

Reason for therapeutic X-rays listed above in questions 1-5.

Please print — Stay within box

45. Have you personally ever undergone any diagnostic or therapeutic radioisotope procedures? Here we are interested in procedures performed on you, not those performed by you.

- Yes No Don't know

IF YOU MARKED NO OR DON'T KNOW, SKIP TO QUESTION 47.

46. Has any part of your body ever been treated or diagnosed with radioisotopes? Please mark (a) "Yes" or "No" for each part of the body indicating whether or not you had been treated or diagnosed with radioisotopes. For each "Yes" indicate (b) the purpose of the radioisotope procedure, (c) the type of isotope used, (d) the number of times you had the procedure and (e) the year the procedure was done for the first time.

1. Thyroid — treated or diagnosed with radioisotopes?

a. Yes No d. No. of times e. Yr. first done

 19

- b. Therapeutic
 Diagnostic
 Both

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9

c. Type of isotope

- ¹³¹I
 ^{99m}Tc
 Other (please specify →)

2. Sites other than the thyroid treated or diagnosed with radioisotopes?

a. Yes No b. Therapeutic

If yes, please specify site: →

- Diagnostic
 Both

d. No. of times e. Yr. first done

 19

c. Type of isotope

- ^{99m}Tc
 ¹³¹I
 ¹⁹⁸Au
 ¹⁹⁷Hg
 ²⁰³Hg
 Other (please specify →)

- 0
- 1
- 2
- 3
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- 9

47. When you were training to be a radiologic technologist or radiologic technician, did other students ever practice taking X-rays on you?

- Yes No

48. If yes, how many times?

- 1-9 10-24 25-49 50+

49. Have you or your wife (wives) ever been pregnant?
(Count live births, stillbirths, miscarriages, and abortions.)

- Yes
 No

IF YOU MARKED NO, MALES SKIP TO QUESTION 73,
FEMALES SKIP TO QUESTION 54.

50. How many times have you or your wife (wives) been pregnant?

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

TIMES

51. How many live births have you or your wife (wives) had (count twins as 1 birth)?

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

LIVE BIRTHS

52. How many miscarriages have you or your wife (wives) had?

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

53. How many children were carried to term but stillborn?

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

III. GYNECOLOGICAL HISTORY FEMALES ONLY Males Skip to Question 73

54. Did you ever or do you now take birth control pills?

- Yes No

IF YOU MARKED NO, SKIP TO QUESTION 58.

55. Are you currently taking birth control pills?

- Yes No

56. How old were you when you first took birth control pills?

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

57. Altogether, what was the total number of years you used birth control pills?

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

58. How old were you when your first menstrual period started?

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

59. Have your menstrual periods stopped completely?

- Yes
 No

IF YOU MARKED NO, SKIP TO QUESTION 63.

60. How old were you when your periods stopped completely?

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

61. What was the reason your periods stopped?

- Because of surgery (hysterectomy)
- Natural menopause (change of life)
- Because of radiation treatment I received
- Another reason (describe below)

IF YOU MARKED SURGERY, PLEASE ANSWER QUESTION 62. ALL OTHERS, SKIP TO QUESTION 63.

62. If surgery, how many ovaries were removed?

- Both
- One
- None
- Don't know

63. Some people take hormone pills for hot flashes or mood changes during menopause or because periods have stopped due to an operation. Did you ever take hormone pills for any reasons related to menopause?

- Yes
- No

IF YOU MARKED NO, SKIP TO QUESTION 68.

64. If you took hormone pills for a reason related to menopause, please mark the reason below.

- Hot flashes
- Mood changes
- Because periods had stopped
- Don't know reason

65. How old were you when you first took hormone pills for a reason related to menopause?

		YEARS OLD
0	0	
1	1	
2	2	
3	3	
4	4	
5	5	
6	6	
7	7	
8	8	
9	9	

66. Altogether, how long did you take hormone pills for this reason?

		YEARS		MONTHS
0	0		<input type="radio"/>	1
1	1		<input type="radio"/>	2
2	2		<input type="radio"/>	3
3	3		<input type="radio"/>	4
4	4		<input type="radio"/>	5
5	5		<input type="radio"/>	6
6	6		<input type="radio"/>	7
7	7		<input type="radio"/>	8
8	8		<input type="radio"/>	9
9	9		<input type="radio"/>	10
			<input type="radio"/>	11

67. Are you currently taking hormone pills for this reason?

- Yes
- No

68. Have you ever had a breast biopsy?

- Yes
- No

IF YOU MARKED NO, SKIP TO QUESTION 71.

69. What year was your first breast biopsy?

19		
0	0	
1	1	
2	2	
3	3	
4	4	
5	5	
6	6	
7	7	
8	8	
9	9	

70. How many breast biopsies have you had?

		NUMBER
0	0	
1	1	
2	2	
3	3	
4	4	
5	5	
6	6	
7	7	
8	8	
9	9	

71. Have any members of your immediate family, that is, grandmother, mother, aunt, sister, or daughter, had breast cancer?

- Yes
- No

IF YOU MARKED NO, SKIP TO QUESTION 73.

72. Mark all those relatives who have had breast cancer.

- Grandmother
- Mother
- Sister
- Daughter
- Maternal Aunt
- Paternal Aunt

IV. CURRENT ADDRESS INFORMATION

73. We are requesting your Social Security Number because it would be helpful in locating your whereabouts if we wished to contact you in a few years. Disclosure of your Social Security Number is voluntary. Refusing to provide your Social Security Number will in no way affect any rights, benefits or privileges which you may now or in the future be receiving.

My Social Security Number is:

I don't have a Social Security Number.

0	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9	9

74. It would also be helpful if you could provide us with the name and address of someone who could give us your new address should you move. We would contact this person only if we are unable to reach you at your home address.

Name: _____		
First	Last	Relationship to you
Address: _____		
Street		
City	State	ZIP Code

75. Please sign the consent form on the back of this questionnaire.

Please use this space for any additional comments or information.

University of Minnesota
American Registry of Radiologic Technologists
National Institutes of Health Collaborative Health Study

AUTHORIZATION TO OBTAIN MEDICAL and/or DOSIMETRY RECORDS

I hereby voluntarily authorize the study investigators at the University of Minnesota to request and obtain my medical records from my physician or from a hospital where I have been seen and to request and obtain dosimetry information from previous or current employers.

I understand that:

- 1) the information obtained from medical records will be used to evaluate the possible health effects of occupational radiation exposures.
- 2) the survey is authorized by the general provisions of the Public Health Service Act.
- 3) the information obtained from any of my records will be kept strictly confidential.
- 4) neither my name nor any other identifying information will ever appear in any report of this survey.
- 5) I may withdraw this consent at any time without prejudice.

This authorization is valid for a period of one year from the date of signature.

Signature

Date

Please check each page carefully to make certain you have answered all questions that apply to you. Pay particular attention to the tables, then mail back the questionnaire in the enclosed envelope.

THANK YOU VERY MUCH FOR YOUR COOPERATION.