Code: _____

FERNALD PROJECT

QUESTIONNAIRE FOR PARENTS

ADAPTED FROM QUESTIONNAIRE PREPARED BY CHILDRENS CANCER STUDY GROUP

1. What is today's date? _____/_____/19_____
   Month Day Year

2. What is your relationship to the patient?

   Natural (biologic) mother |__|
   Natural (biologic) father |__|
   Adoptive mother |__|
   Adoptive father |__|
   Other (specify _____) |__|

Many of the following questions concern the natural parents of the patient. If you are not the natural mother or father, and you don't know some of the answers, just check the "Unknown" box.

EXPOSURES AROUND TIME OF PREGNANCY

The next few questions ask about possible exposures the natural parents may have had around the time of the pregnancy (before the patient was born).

3. Did the natural mother smoke cigarettes in the three months before the pregnancy or during the pregnancy?

   Yes |__| No |__| Unknown |__|

   If yes, how many cigarettes did she smoke per day:

   (a) before the pregnancy _____ cigarettes per day
   and
   (b) during the pregnancy _____ cigarettes per day

4. Did the natural father smoke cigarettes in the three months before the pregnancy or during the pregnancy?

   Yes |__| No |__| Unknown |__|

   If yes, how many cigarettes did he smoke per day:

   (a) before the pregnancy _____ cigarettes per day
   and
   (b) during the pregnancy _____ cigarettes per day

Code: _____

5. During the pregnancy how often did the natural mother drink:

Decaffinated coffee	_____	cups per day
Regular coffee or tea	_____	cups per day
Alcohol (beer, wine, liquor, etc.)	_____	drinks per week

6. Did the natural mother have any of the following infections during the pregnancy or in the three months before the pregnancy?

	YES	NO	UNKNOWN	If YES, at What Month During or Before the Pregnancy: In the 3 months before the pregnancy	DURING PREGNANCY 1-3 months	4-6 months	7-9 months
Rubella (German measles)	☐	☐	☐	☐	☐	☐	☐
Measles	☐	☐	☐	☐	☐	☐	☐
Mumps	☐	☐	☐	☐	☐	☐	☐
Influenza or pneumonia	☐	☐	☐	☐	☐	☐	☐
Mononucleosis (infectious mono or glandular fever)	☐	☐	☐	☐	☐	☐	☐
Genital Herpes	☐	☐	☐	☐	☐	☐	☐
Chickenpox or shingles	☐	☐	☐	☐	☐	☐	☐
Urinary infection	☐	☐	☐	☐	☐	☐	☐
Rheumatic fever	☐	☐	☐	☐	☐	☐	☐
Other infections Please specify type of infection _____	☐	☐	☐	☐	☐	☐	☐

7. Was the father taking any medications or drugs at the time the pregnancy began?

Yes ☐ No ☐ Unknown ☐

If yes, please specify the drugs _____

Code: _____

8. Did the mother take any medications during the pregnancy or the three months before pregnancy?

MEDICATION	YES	NO	UNKNOWN	If YES, at What Month During or Before the Pregnancy: In the 3 months before the pregnancy	DURING PREGNANCY 1-3 months	4-6 months	7-9 months
Birth control pills Please give brand_____	☐	☐	☐	☐	☐	☐	☐
Hormones such as thyroid, cortisone or insulin Please specify _____	☐	☐	☐	☐	☐	☐	☐
Vitamins, iron, or liver pills	☐	☐	☐	☐	☐	☐	☐
Medicine for nausea or vomiting	☐	☐	☐	☐	☐	☐	☐
Diuretics (water pills)	☐	☐	☐	☐	☐	☐	☐
Blood pressure medicine Please specify _____	☐	☐	☐	☐	☐	☐	☐
Medicine to control seizures Please specify _____	☐	☐	☐	☐	☐	☐	☐
Sleeping pills, tranquilizers or muscle relaxants Please specify _____	☐	☐	☐	☐	☐	☐	☐
Pain relievers including aspirin	☐	☐	☐	☐	☐	☐	☐
Diet pills Please specify _____	☐	☐	☐	☐	☐	☐	☐
Antibiotics Please specify _____	☐	☐	☐	☐	☐	☐	☐
Other drugs, including any non-prescription drugs Please specify: _____ _____	☐	☐	☐	☐	☐	☐	☐
"Recreational" drugs such as LSD, marijuana, cocaine, etc. Please specify_____	☐	☐	☐	☐	☐	☐	☐

Code: _____

9. Was the natural mother given a tablet or injection (shot) by her doctor to test if she was pregnant? (This would have brought on her period had she not been pregnant.)

YES _____ NO _____ UNKNOWN _____

10. Has either natural parent ever seen a doctor because of infertility or difficulty getting pregnant?

YES _____ NO _____ UNKNOWN _____

If yes, what treatment did the doctor give?

None _____
Clomid or other hormone injections _____
Surgery _____
Other _____ _____

Please describe the treatment and indicated when it was given.

_____

_____

11. Did the natural mother have a job in the three months before or during the pregnancy?

YES _____ NO _____ UNKNOWN _____

If yes,

What was the job title? _____

What did she do? _____

Company (employer) _____

List other employers (companies) she has worked for between 1952 and 1984. _____

_____

_____

12. Did the natural father have a job in the three months before or during the pregnancy?

YES _____ NO _____ UNKNOWN _____

If yes,

What was the job title? _____

What did he do? _____

Company (employer) _____

Code: _____

13. We would like to know if the patient or either natural parent was exposed to any of the substances listed below. Only include exposures lasting six months or more. Indicate whether the parent's exposure came before, during, or after the pregnancy.

Do not include exposures to cleaning compounds around the house unless the exposure was much greater than average.

Do not include exposure to gasoline if you only fill your own car's tank.

		PATIENT			PARENTS						If YES, was the exposure		
					Natural Mother			Natural Father					
	Please specify name of substance	Yes	No	Unknown	Yes	No	Unknown	Yes	No	Unknown	Before Pregnancy	During Pregnancy	After Pregnancy
Chemical or solvents (eg. laboratory chemicals, benzene, acetone)	_____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Paints, lacquers, or stains	_____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Radiation (eg. x-rays, radium, uranium, nuclear, ultraviolet light, microwaves)	_____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Plastic or resin fumes	_____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Gases (eg. ammonia, chlorine, nitrous oxide, ethane)	_____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Engine exhaust fumes	_____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Petroleum products (eg. gasoline, oil, propane, tar)	_____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Dusts (eg. coal, wood, silicon, asbestos, talc)	_____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Code: _____

	Please specify name of substance	PATIENT Yes	PATIENT No	PATIENT Unknown	PARENTS Natural Mother Yes	PARENTS Natural Mother No	PARENTS Natural Mother Unknown	PARENTS Natural Father Yes	PARENTS Natural Father No	PARENTS Natural Father Unknown	If YES, was the exposure Before Pregnancy	If YES, was the exposure During Pregnancy	If YES, was the exposure After Pregnancy
Dyes (including hair dye)	_____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Metals - in molten form (eg. lead, aluminum, iron, copper, nickel, zinc, mercury, solder)	_____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Insecticides or herbicides	_____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
		—	—	—	—	—	—	—	—	—	—	—	—
Cleaning compounds (eg. bleach, detergent, ammonia, borax)	_____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other (specify)	_____	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Code: _____

PREGNANCY AND BIRTH

In this section we will be asking about any complications of the pregnancy or birth (when the patient was born)

14. During the pregnancy or during the 3 months before pregnancy, did the mother ever experience...?

	YES	NO	DON'T KNOW	If YES, at What Month During or Before the Pregnancy: In the 3 months before the pregnancy	DURING PREGNANCY 1-3 months	4-6 months	7-9 months
Spotting, cramping, or abnormal vaginal bleeding	☐	☐	☐	☐	☐	☐	☐
Severe nausea and/or vomiting	☐	☐	☐	☐	☐	☐	☐
High blood pressure or toxemia	☐	☐	☐	☐	☐	☐	☐
Sugar or albumin protein in urine	☐	☐	☐	☐	☐	☐	☐
Infections such as venereal disease, or vaginal or urinary tract infections Please specify _____	☐	☐	☐	☐	☐	☐	☐
Severe swelling of face or hands	☐	☐	☐	☐	☐	☐	☐
General anesthesia (put to sleep) for surgery or dental work State reason _____	☐	☐	☐	☐	☐	☐	☐
Caesarean section. State reason _____	☐	☐	☐				
X-rays (including dental) State reason _____	☐	☐	☐	☐	☐	☐	☐
Ultrasound examinations (with a hand held probe run up and down the abdomen) State reason _____	☐	☐	☐	☐	☐	☐	☐
Amniocentesis (fluid taken by needle from the uterus) State reason _____	☐	☐	☐		☐	☐	☐

Code: _____

15. How long did the pregnancy last? (a "full term" pregnancy is 40 weeks)

____ months or ____ weeks

16. In what city was the patient born?

City	State (if US born) Country (if born outside USA)	Zip Code

17. What was the patient's weight at birth? ____ pounds ____ ounces

18. Did the patient have any of the following problems at birth or within the first six months after birth?

	Yes	No	Unknown
Jaundice	☐	☐	☐
Infection	☐	☐	☐
Diarrhea and/of vomiting	☐	☐	☐
Feeding problems	☐	☐	☐
Other: please specify _____	☐	☐	☐

19. Did the patient receive any of the following treatments at birth or within the first six months after birth?

	Yes	No	Unknown
Special or UV lights for yellow color (jaundice)	☐	☐	☐
Oxygen or respirator	☐	☐	☐
Blood transfusions	☐	☐	☐
Medicines specify _____	☐	☐	☐

20. Was he/she breast fed?

Yes ☐ No ☐ Unknown ☐ If yes, for how long? ____ months

Code: _____

FAMILY MEDICAL HISTORY

21. Birthdate of natural mother: _____/___/19____
month day year

22. Birthdate of natural father: _____/___/19____
month day year

23. We would like some information about the four natural grandparents of the patient. Please give their country of birth, indicate whether they are still alive, and give their ages (or age at which the died).

Grandparents of Patient	Country of Birth	Alive	Dead	Unknown	Age now or at death
Mother's mother	_____	☐	☐	☐	_____
Mother's father	_____	☐	☐	☐	_____
Father's mother	_____	☐	☐	☐	_____
Father's father	_____	☐	☐	☐	_____

24. Have any of these family members had cancer (including leukemia)?

Grandparents of Patient	Yes	No	Unknown	Type of Cancer	Age cancer was diagnosed
Mother's mother	☐	☐	☐	_____	_____
Mother's father	☐	☐	☐	_____	_____
Father's mother	☐	☐	☐	_____	_____
Father's father	☐	☐	☐	_____	_____
Natural mother	☐	☐	☐	_____	_____
Natural father	☐	☐	☐	_____	_____
Any brother or sister of patient	☐	☐	☐	_____	_____

25. Left blank intentionally.

26. Do you know of any blood relative of the patient who had any type of cancer before age 21?

Yes ☐ No ☐

If yes, please give cancer type, relative affected and age diagnosed. _____

Code: _____

27. Please list all pregnancies (including stillbirths, abortions, and miscarriages) of the patient's natural mother. Begin with the oldest child and end with the youngest child. Please include the patient on this list. If you cannot remember some details, just leave them blank.

	PREGNANCIES: Enter FIRST NAME OF CHILD or write "MISCARRIAGE", "ABORTION" or "STILLBIRTH"	SEX: MALE	SEX: FEMALE	SEX: UNKNOWN	DATE OF BIRTH, MISCARRIAGE, ABORTION, OR STILLBIRTH (Month/Day/Year)	LENGTH OF PREGNANCY (Weeks)	BIRTH WEIGHT
First/ oldest	1. _____	☐	☐	☐	___/___/___	_____	_____
	2. _____	☐	☐	☐	___/___/___	_____	_____
	3. _____	☐	☐	☐	___/___/___	_____	_____
	4. _____	☐	☐	☐	___/___/___	_____	_____
	5. _____	☐	☐	☐	___/___/___	_____	_____
	6. _____	☐	☐	☐	___/___/___	_____	_____
	7. _____	☐	☐	☐	___/___/___	_____	_____
	8. _____	☐	☐	☐	___/___/___	_____	_____
	9. _____	☐	☐	☐	___/___/___	_____	_____
	10. _____	☐	☐	☐	___/___/___	_____	_____

Office use:

Number of pregnancies |_|_|

Number of live births |_|_|

Birthorder of patient |_|_|

Twin, triplet, etc |_|
1= Yes, 2= No, 9= Unknown

NOTE: A full term pregnancy is 40 weeks.

Code: _____

The following questions are concerned with diseases the patient has had and diseases of the patient's natural parents and grandparents, and brothers and sisters. For each category put a cross (X) in a box when a family member has had the disease; otherwise leave the box empty. Use the next page to give further details about the disease.

28. What birth defects have there been in the patient's family? Note that "congenital" defects are those one is born with.

	Patient	Natural Mother	Natural Father	Any Grand-parent of Patient	Brother or Sister of Patient
Congenital abnormalities of heart or lungs (eg. hole in heart)	☐	☐	☐	☐	☐
Cleft lip (harelip) or cleft palate	☐	☐	☐	☐	☐
Congenital defect of limbs (eg. dislocated hip, club foot, extra finger)	☐	☐	☐	☐	☐
Congenital defects of kidneys, urinary system or genitals	☐	☐	☐	☐	☐
Congenital abnormalities of intestines	☐	☐	☐	☐	☐
Abnormalities of head or spine (eg. hydrocephalus, spina bifida)	☐	☐	☐	☐	☐
Inherited blood disease (eg. sickle cell, hemophilia)	☐	☐	☐	☐	☐
Cystic fibrosis	☐	☐	☐	☐	☐
Down's syndrome or mongolism	☐	☐	☐	☐	☐
Turner's syndrome or other chromosomal abnormality	☐	☐	☐	☐	☐
Cerebral palsy	☐	☐	☐	☐	☐
Mental retardation	☐	☐	☐	☐	☐
Congenital blindness or eye abnormalities	☐	☐	☐	☐	☐
Congenital deafness or hearing impairment	☐	☐	☐	☐	☐
Other hereditary or birth defects	☐	☐	☐	☐	☐

Code: _____

Please note the name of the disease, who had it (eg. which grandparent,brother or sister), and at what age it was diagnosed.

Code: _____

29. Which of the following diseases have been diagnosed by a doctor in members of the patient's family?

Please use the next page to further describe these conditions.

	Patient	Natural Mother	Natural Father	Any Grand-parent of Patient	Brother or Sister of Patient
Blood disorders (eg. anemia not responsive to iron)	☐	☐	☐	☐	☐
Eye or ear problems (eg. blindness, deafness, glaucoma)	☐	☐	☐	☐	☐
Lung disease (eg. emphysema, sarcoidosis, "black lung")	☐	☐	☐	☐	☐
Cardiovascular disease (eg. high blood pressure, heart attack, stroke)	☐	☐	☐	☐	☐
Liver disease (eg. hepatitis, cirrhosis)	☐	☐	☐	☐	☐
Intestinal disorders (eg. diverticulosis, Crohn's disease, colitis)	☐	☐	☐	☐	☐
Kidney disease (eg. chronic infection, nephritis)	☐	☐	☐	☐	☐
Disorders of the bones or joints (eg. arthritis, Paget's disease)	☐	☐	☐	☐	☐
Thyroid problem	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Epilepsy or seizures	☐	☐	☐	☐	☐
Nervous system disorders (eg. multiple sclerosis, Parkinson's disease)	☐	☐	☐	☐	☐
Skin disease (eg. eczema, psoriasis, skin ulcers)	☐	☐	☐	☐	☐
Mental or emotional problems (eg. learning disability, depression, anxiety)	☐	☐	☐	☐	☐
Alcoholism or drug addiction	☐	☐	☐	☐	☐
Allergies (eg. hives, asthma, hay fever, severe allergies to foods or medicines)	☐	☐	☐	☐	☐
Benign tumors ("growths" or cysts)	☐	☐	☐	☐	☐
Other serious illnesses (eg. SLE, dermatomyositis, scleroderma)	☐	☐	☐	☐	☐

Code: _____

Please note the name of the disease, who had it (eg. which grandparent,brother or sister), and at what age it was diagnosed.

Code: _____

30. Child's immunization and tests (shots record)

TYPE	DATES GIVEN
DTP (diphtheria, tetanus, whooping cough)	_____
Oral polio (Sabin)	
1. Trivalent	_____
2. Monovalent	_____
MMR (measles, mumps rubella, see below if given separately)	_____
Measles (rubeola or regular measles)	_____
Rubella (German Measles)	_____
Mumps	_____
Hemophilus b (H-flu vaccine)	_____
Td (adult tetanus and diphtheria)	_____
Tuberculin test	_____
Others (specify)	_____

31. Has the patient ever had any of the following illnesses?

	YES	NO	UNKNOWN
Chicken pox	☐	☐	☐
Cold sores (blisters around mouth)	☐	☐	☐
Rheumatic fever	☐	☐	☐
Hepatitis	☐	☐	☐
Infectious mononucleosis (mono, glandular fever)	☐	☐	☐
Mumps	☐	☐	☐
Measles (regular)	☐	☐	☐
German measles	☐	☐	☐

Code: _____

	YES	NO	UNKNOWN
32. Have the patient's tonsils or adenoids been removed?	☐	☐	☐
33. Has the patient's appendix been removed?	☐	☐	☐

34. Did the PATIENT take any of the following medicines or drugs at any time?

	YES	NO	UNKNOWN	DESCRIBE (Include brand name of drug and approximate time used)
Thyroid medicine	☐	☐	☐	_____
Amphetamines or diet pills	☐	☐	☐	_____
Medicines for convulsions (anticonvulsants such as Dilantin)	☐	☐	☐	_____
Steroids or immunosuppressives (such as prednisone, cytoxan)	☐	☐	☐	_____
Antibiotics (such as penicillin, isoniazid, chloramphenicol)	☐	☐	☐	_____
Tranquilizers, nerve medicines, sedatives, muscle relaxants, or sleeping pills	☐	☐	☐	_____
High blood pressure medicine (such as reserpine)	☐	☐	☐	_____
Anti-inflammatory agents (such as phenylbutazone)	☐	☐	☐	_____
Allergy shots or medicine for allergy	☐	☐	☐	_____
Vitamins	☐	☐	☐	_____
"Recreational" drugs (such as marijuana, LSD, cocaine)	☐	☐	☐	_____

Code: _____

DEVELOPMENT

35. At what age did the patient first walk without any support?

_____Years _____ Months

36. Has the patient attended school?

_____Yes _____ No

If yes, circle the current or highest grade completed:

Preschool Kindergarten 1 2 3 4 5 6 7 8 9 10 11 12

37. Has the child been in any special classes for learning difficulties or behavior problems?

_____Yes _____ No

If yes, please describe _____

_____

_____

38. Has he/she received individual help from teachers or tutors?

_____Yes _____ No

If yes, approximate number of hours per week _____

For what subjects _____

_____

39. Has he/she received any of the following:

Speech therapy Yes _____ No _____

Physical therapy Yes _____ No _____

Code: _____

PATIENT'S HOME ENVIRONMENT

40. Which of the following best describes the type of housing in which the patient lived from 1952 to 1985? (check on box only)

1. Single Family House ____
2. Multiple Family House ____
3. Townhouse or apartment ____
5. Group quarters ____ (eg. dormitories)
6. Mobile Home ____
7. Other (specify) ____ _____

41. Was this residence exterminated for insects or pests?

Yes _____ No _____ Unknown _____

42. Were there pets in the household?

Yes _____ No _____

If yes, specify:

Dog _____ Cat ____ Bird ____ Other (specify) _____ _____

We would like some information about the social and ethnic background.

43. What is the highest schooling completed by the present parents or guardians of the child?

	Mother	Father
1. 0 - 12th grade	_____	_____
2. High school diploma	_____	_____
3. Vocational or Technical Training School	_____	_____
4. College degree (BA, BS) _____	_____	_____
5. Graduate school degree (MA, Ph.D., M.D., etc.)	_____	_____

Code: _____

44. In what faith is the patient being raised?

1. Protestant |__|
2. Catholic |__|
3. Jewish |__|
4. Latter Day Saints (Mormons) |__|
5. Seventh Day Adventist |__|
6. Muslim |__|
7. Eastern religion (Hindu, Buddhist, Shinto) |__|
8. None |__|
9. Other (specify _ _____) |__|

45. What race are the natural parents of the patient (choose one only)?

	Natural Mother	Natural Father
1. White, non-Hispanic	|__|	|__|
2. White, wish Spanish as native language	|__|	|__|
3. Black	|__|	|__|
4. Oriental	|__|	|__|
5. American Indian	|__|	|__|
6. Other (specify _____)	|__|	|__|

Code: _____

46. Are the natural mother and natural father of the patient related to <u>each other</u> by blood?

Yes _____ No _____ Unknown _____ If yes, please state the relationship (for example second cousins):

_____

47. Do you have any additional comments or concerns about the health of your child?

_____

_____

_____

_____

_____

_____

_____

THANK YOU FOR YOUR TIME AND COOPERATION IN FILLING OUT THIS QUESTIONNAIRE.