



Core Questionnaire



Variable List

Office use only

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Directions For Completing This Questionnaire

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

- We appreciate you completing the whole questionnaire. However, if you prefer not to answer a question write '**Decline**' beside it.

- Use a ballpoint pen, **not a felt pen**.



- Shade in the bubbles completely, like this: ☒

- Write numbers in boxes like this:

2	1
---	---

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:



- **Before starting the questionnaire please make sure to gather your prescription medications and a tape measure so these items are handy.**
- Please leave the booklet stapled together. The pages will be separated at the study centre.

If you are not sure how to answer a question, please feel free to contact us:

Atlantic Path:

Halifax Area 494-7284
Toll Free 1-877-285-7284
info@atlanticpath.ca

Ontario Health Study:

1-866-606-0686
info@ontariohealthstudy.ca

BC Generations Project:

Lower Mainland 604-675-8221
Toll Free 1-877-675-8221
bcgenerationsproject@bccrc.ca

The Tomorrow Project (Alberta):

Toll Free 1-877-919-9292
Outside Canada call collect
1-403-476-2469
tomorrow@albertahealthservices.ca

CARTaGENE:

1-877-263-2360
service.cartagene@ramq.gouv.qc.ca



DEMOGRAPHIC INFORMATION

- DE01 What is your date of birth? DD MM YYYY
/ /
CORE_DE02_SEX
- DE02 What is your sex? 1 ☐ Male 2 ☐ Female
3 ☐ = Other Gender

FAMILY CHARACTERISTICS

CORE_FA01_MARITAL_STATUS

- FA01 What is your current marital status? Please choose the **ONE** that best describes your current situation.
- 1 ☐ Married and/or living with a partner
2 ☐ Divorced
3 ☐ Widowed
4 ☐ Separated
5 ☐ Single, never married

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

CORE_FA02_NUM_BROTHERS
[] [] Brothers →

CORE_FA02_NUM_SISTERS
[] [] Sisters →

CORE_FA02_NUM_SIBLINGS_Ca
1 ☐ Don't Know →

If "0" BROTHERS AND "0" SISTERS OR
"DON'T KNOW", SKIP TO FA05 (THIS PAGE)

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

CORE_FA03_NUM_OLDER_SIBLINGS
[] [] Siblings older than me

CORE_FA03_NUM_OLDER_SIBLINGS_Ca
99 ☐ Don't know

CORE_FA04_MULTIPLE_BIRTH

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

- 1 ☐ Yes
0 ☐ No
9 ☐ Don't know

CORE_FA05_ADOPTED

- FA05 Were you adopted?

- 1 ☐ Yes
0 ☐ No
9 ☐ Don't know



EDUCATION LEVEL

CORE_EL01_HIGHEST_EDU

EL01 What is the highest level of education you have completed? (Choose **ONE** only)

- 1 ☐ Elementary School
- 2 ☐ High School
- 3 ☐ Trade, technical or vocation school, apprenticeship training or technical CEGEP
- 4 ☐ Diploma from a community college, pre-university CEGEP or non-university certificate
- 5 ☐ University certificate below Bachelor's level
- 6 ☐ Bachelor's degree
- 7 ☐ Graduate degree (MSc, MBA, MD, PhD, etc.)
- 0 ☐ None



SKIP TO HEALTH STATUS - HS01 (NEXT PAGE)

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

CORE_EL02_AGE_EDU_COMPLETED

Age when you completed highest level of education

CORE_EL02_AGE_EDU_COMPLETED_Ca

99 ☐ Don't know



HEALTH STATUS

CORE_HS01_HEALTH_GEN_PERCEPT

HS01 How would you rate your general health?

- 5 ○ Excellent
- 4 ○ Very good
- 3 ○ Good
- 2 ○ Fair
- 1 ○ Poor

CORE_HS02_LAST_MED_EXAM

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

- 1 ○ Less than 6 months ago
- 2 ○ 6 months to less than 1 year ago
- 3 ○ 1 year to less than 2 years ago
- 4 ○ 2 years to less than 3 years ago
- 5 ○ 3 or more years ago
- 0 ○ Never
- 9 ○ Don't know

CORE_HS03_LAST_DENTIST

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

- 1 ○ Less than 6 months ago
- 2 ○ 6 months to less than 1 year ago
- 3 ○ 1 year to less than 2 years ago
- 4 ○ 2 years to less than 3 years ago
- 5 ○ 3 or more years ago
- 0 ○ Never
- 9 ○ Don't know

CORE_HS04_LAST_FOBT

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

- 1 ○ Less than 6 months ago
- 2 ○ 6 months to less than 1 year ago
- 3 ○ 1 year to less than 2 years ago
- 4 ○ 2 years to less than 3 years ago
- 5 ○ 3 or more years ago
- 0 ○ Never
- 9 ○ Don't know



CORE_HS05_LAST_COLONOSCOPY

HS05 When was the last time you had a colonoscopy? A colonoscopy is an exam where a long tube is used to examine the entire colon for signs of cancer or other health problems. Before the procedure is done, you are usually given a sedative.

- 1 ☐ Less than 6 months ago
- 2 ☐ 6 months to less than 1 year ago
- 3 ☐ 1 year to less than 2 years ago
- 4 ☐ 2 years to less than 3 years ago
- 5 ☐ 3 or more years ago
- 0 ☐ Never
- 9 ☐ Don't know

CORE_HS06_LAST_SIGMOIDOSCOPY

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

- 1 ☐ Less than 6 months ago
- 2 ☐ 6 months to less than 1 year ago
- 3 ☐ 1 year to less than 2 years ago
- 4 ☐ 2 years to less than 3 years ago
- 5 ☐ 3 or more years ago
- 0 ☐ Never
- 9 ☐ Don't know

CORE_HS07_POLYPS

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

- 1 ☐ Yes
- 0 ☐ No
- 9 ☐ Don't know



MEN'S HEALTH

CORE_MH01_LAST_PSA

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

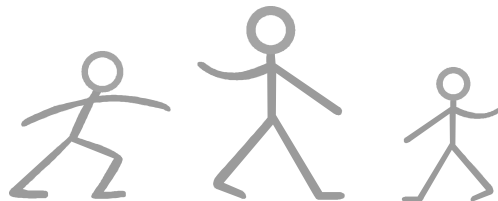
- 1 ☐ Less than 6 months ago
- 2 ☐ 6 months to less than 1 year ago
- 3 ☐ 1 year to less than 2 years ago
- 4 ☐ 2 years to less than 3 years ago
- 5 ☐ 3 or more years ago
- 0 ☐ Never
- 9 ☐ Don't know

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

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Children
CORE_MH02_NUM_CHILD_FATHERED
CORE_MH02_NUM_CHILD_FATHERED_Ca

99 ☐ Don't know



WOMEN'S HEALTH

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

CORE_WH01_MENSTRUATION_START_AGE

Age at first menstrual period

1 ☐ Never had a menstrual period

99 ☐ Don't know

CORE_WH02_CONTRACEPTIVE_USE

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

1 ☐ Yes

0 ☐ No

9 ☐ Don't know

→ → SKIP TO WH05 (THIS PAGE)

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

Age when started using hormonal contraceptives

99 ☐ Don't know

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

Years **OR**

Months

99 ☐ Don't know

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

CORE_WH05_NUM_PREG_ALL

Number of pregnancies

CORE_WH05_NUM_PREG_ALL_Ca

1 ☐ Never been pregnant

99 ☐ Don't know

→ → SKIP TO WH12 (NEXT PAGE)

WH06 How old were you when you first became pregnant?

CORE_WH06_FIRST_PREG_AGE

Age at first pregnancy

CORE_WH06_FIRST_PREG_AGE_Ca

99 ☐ Don't know

CORE_WH07_PREGNANT

WH07 Are you currently pregnant? CORE_WH07_PREGNANCY_STAGE

1 ☐ Yes → In what week are you? Weeks

0 ☐ No

9 ☐ Don't know

If YES and it's your first pregnancy, SKIP TO WH12 (THIS PAGE)

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

CORE_WH08_NUM_PREG_20_WKS
Pregnancies

99 ☐ Don't know CORE_WH08_NUM_PREG_20_WKS_Ca

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

CORE_WH09_NUM_LIVE_BIRTHS
Live births

99 ☐ Don't know CORE_WH09_NUM_LIVE_BIRTHS_Ca

WH10 How old were you when you last became pregnant?

CORE_WH10_LAST_PREG_AGE
Age at last pregnancy

99 ☐ Don't know CORE_WH10_LAST_PREG_AGE_Ca

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

CORE_WH11_NUM_MOS_BREASTFED
Months

9999 ☐ Don't know CORE_WH11_NUM_MOS_BREASTFED_Ca

CORE_WH12_FERTILITY_TX_EVER

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

1 ☐ Yes

0 ☐ No

9 ☐ Don't know

CORE_WH13_MENOPAUSE_OCCURRENCE

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

1 ☐ Yes, natural menopause

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

0 ☐ No

9 ☐ Don't know

→ SKIP TO WH15 (NEXT PAGE)

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

CORE_WH14_MENOPAUSE_START_AGE

Age when menstrual periods stopped

CORE_WH14_MENOPAUSE_START_AGE_Ca

99 ☐ Don't know

CORE_WH15_HRT_EVER

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

1 ☐ Yes

0 ☐ No

9 ☐ Don't know

→ SKIP TO WH18 (THIS PAGE)

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

CORE_WH16_HRT_AGE_STARTED

Age when started using hormone replacement therapy

CORE_WH16_HRT_AGE_STARTED_Ca

99 ☐ Don't know

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

CORE_WH17_HRT_DURATION_YR CORE_WH17_HRT_DURATION_MT

Years **OR**

Months

99 ☐ Don't know CORE_WH17_HRT_DURATION_Ca

CORE_WH18_HYSTERECTOMY_EVER

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

1 ☐ Yes

0 ☐ No

9 ☐ Don't know

→ SKIP TO WH20 (NEXT PAGE)

WH19 How old were you when you had your hysterectomy?

CORE_WH19_HYSTERECTOMY_AGE

Age at hysterectomy

CORE_WH19_HYSTERECTOMY_AGE_Ca

99 ☐ Don't know



CORE_WH20_OOPHORECTOMY

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

1 ☐ Yes

0 ☐ No

9 ☐ Don't know

→ SKIP TO WH24 (THIS PAGE)

CORE_WH21_OOPHORECTOMY_TYPE

WH21 Did you have one or both ovaries removed?

2 ☐ Both

1 ☐ One

9 ☐ Don't know

→ SKIP TO WH23 (THIS PAGE)

CORE_WH22_OOPHORECTOMY_NUMBER

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

1 ☐ Yes

2 ☐ No

3 ☐ Don't know

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

--	--

CORE_WH23_OOPHORECTOMY_AGE_LAST
Age at last surgery

99 ☐ Don't know

CORE_WH24_LAST_MAMMOGRAM

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

1 ☐ Less than 6 months ago

2 ☐ 6 months to less than 1 year ago

3 ☐ 1 year to less than 2 years ago

4 ☐ 2 years to less than 3 years ago

5 ☐ 3 or more years ago

0 ☐ Never

9 ☐ Don't know

CORE_WH25_LAST_PAP_TEST

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

1 ☐ Less than 6 months ago

2 ☐ 6 months to less than 1 year ago

3 ☐ 1 year to less than 2 years ago

4 ☐ 2 years to less than 3 years ago

5 ☐ 3 or more years ago

0 ☐ Never

9 ☐ Don't know



PERSONAL MEDICAL HISTORY

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

	Condition		Diagnosed		Age at first Diagnosis
CORE_PM01_HIGH_BP	High blood pressure (hypertension, not including during pregnancy)	1 0 9	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	 	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div>CORE_PM01_HIGH_BP_ONSET</div> </div> <div style="display: flex; align-items: center;"> <input type="radio"/> Don't know <div style="margin-left: 10px;">CORE_PM01_HIGH_BP_ONSET_CA</div> </div>
CORE_PM01_MI	Heart attack (myocardial infarction)	1 0 9	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	 	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div>CORE_PM01_MI_ONSET</div> </div> <div style="display: flex; align-items: center;"> <input type="radio"/> Don't know <div style="margin-left: 10px;">CORE_PM01_MI_ONSET_CA</div> </div>
CORE_PM01_STROKE	Stroke	1 0 9	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	 	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div>CORE_PM01_STROKE_ONSET</div> </div> <div style="display: flex; align-items: center;"> <input type="radio"/> Don't know <div style="margin-left: 10px;">CORE_PM01_STROKE_ONSET_CA</div> </div>
CORE_PM01_ASTHMA	Asthma	1 0 9	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	 	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div>CORE_PM01_ASTHMA_ONSET</div> </div> <div style="display: flex; align-items: center;"> <input type="radio"/> Don't know <div style="margin-left: 10px;">CORE_PM01_ASTHMA_ONSET_CA</div> </div>
CORE_PM01_COPD	Chronic obstructive pulmonary disease	1 0 9	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	 	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div>CORE_PM01_COPD_ONSET</div> </div> <div style="display: flex; align-items: center;"> <input type="radio"/> Don't know <div style="margin-left: 10px;">CORE_PM01_COPD_ONSET_CA</div> </div>
CORE_PM01_DEPRESSION	Major depression	1 0 9	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	 	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div>CORE_PM01_DEPRESSION_ONSET</div> </div> <div style="display: flex; align-items: center;"> <input type="radio"/> Don't know <div style="margin-left: 10px;">CORE_PM01_DEPRESSION_ONSET_CA</div> </div>
CORE_PM01_DM	Diabetes	1 0 9	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	 	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div>CORE_PM01_DM_ONSET</div> </div> <div style="display: flex; align-items: center;"> <input type="radio"/> Don't know <div style="margin-left: 10px;">CORE_PM01_DM_ONSET_CA</div> </div>
			CORE_PM01_DM_TYPE If yes, which type of diabetes was it? 1 <input type="radio"/> Gestational diabetes only 2 <input type="radio"/> Type 1 diabetes 3 <input type="radio"/> Type 2 diabetes 9 <input type="radio"/> Don't know		
CORE_PM01_CIRRHOSIS	Liver cirrhosis	1 0 9	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	 	<div style="display: flex; align-items: center;"> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div style="border: 1px solid black; width: 30px; height: 30px; margin-right: 5px;"></div> <div>CORE_PM01_CIRRHOSIS_ONSET</div> </div> <div style="display: flex; align-items: center;"> <input type="radio"/> Don't know <div style="margin-left: 10px;">CORE_PM01_CIRRHOSIS_ONSET_CA</div> </div>



	Condition	Diagnosed	Age at first Diagnosis
CORE_PM01_HEPATITIS	Chronic hepatitis	1 <input type="radio"/> Yes 0 <input type="radio"/> No 9 <input type="radio"/> Don't know	<div> <div></div> <div></div> </div> CORE_PM01_HEPATITIS_ONSET 99 <input type="radio"/> Don't know CORE_PM01_HEPATITIS_ONSET_CA
CORE_PM01_CROHNS	Crohn's disease	1 <input type="radio"/> Yes 0 <input type="radio"/> No 9 <input type="radio"/> Don't know	<div> <div></div> <div></div> </div> CORE_PM01_CROHNS_ONSET 99 <input type="radio"/> Don't know CORE_PM01_CROHNS_ONSET_CA
CORE_PM01_COLITIS	Ulcerative colitis	1 <input type="radio"/> Yes 0 <input type="radio"/> No 9 <input type="radio"/> Don't know	<div> <div></div> <div></div> </div> CORE_PM01_COLITIS_ONSET 99 <input type="radio"/> Don't know CORE_PM01_COLITIS_ONSET_CA
CORE_PM01_IBD	Irritable bowel syndrome	1 <input type="radio"/> Yes 0 <input type="radio"/> No 9 <input type="radio"/> Don't know	<div> <div></div> <div></div> </div> CORE_PM01_IBD_ONSET 99 <input type="radio"/> Don't know CORE_PM01_IBD_ONSET_CA
CORE_PM01_ECZEMA	Eczema	1 <input type="radio"/> Yes 0 <input type="radio"/> No 9 <input type="radio"/> Don't know	<div> <div></div> <div></div> </div> CORE_PM01_ECZEMA_ONSET 99 <input type="radio"/> Don't know CORE_PM01_ECZEMA_ONSET_CA
CORE_PM01_LUPUS	Lupus	1 <input type="radio"/> Yes 0 <input type="radio"/> No 9 <input type="radio"/> Don't know	<div> <div></div> <div></div> </div> CORE_PM01_LUPUS_ONSET 99 <input type="radio"/> Don't know CORE_PM01_LUPUS_ONSET_CA
CORE_PM01_PSORIASIS	Psoriasis	1 <input type="radio"/> Yes 0 <input type="radio"/> No 9 <input type="radio"/> Don't know	<div> <div></div> <div></div> </div> CORE_PM01_PSORIASIS_ONSET 99 <input type="radio"/> Don't know CORE_PM01_PSORIASIS_ONSET_CA
CORE_PM01_MS	Multiple sclerosis	1 <input type="radio"/> Yes 0 <input type="radio"/> No 9 <input type="radio"/> Don't know	<div> <div></div> <div></div> </div> CORE_PM01_MS_ONSET 99 <input type="radio"/> Don't know CORE_PM01_MS_ONSET_CA
CORE_PM01_OSTEO	Osteoporosis	1 <input type="radio"/> Yes 0 <input type="radio"/> No 9 <input type="radio"/> Don't know	<div> <div></div> <div></div> </div> CORE_PM01_OSTEO_ONSET 99 <input type="radio"/> Don't know CORE_PM01_OSTEO_ONSET_CA
CORE_PM01_ARTHRITIS	Arthritis	1 <input type="radio"/> Yes 0 <input type="radio"/> No 9 <input type="radio"/> Don't know CORE_PM01_ARTHRITIS_TYPE If yes, which type of arthritis was it? 1 <input type="radio"/> Rheumatoid arthritis 2 <input type="radio"/> Osteoarthritis 3 <input type="radio"/> Other (Please specify): <div></div> 9 <input type="radio"/> Don't know	<div> <div></div> <div></div> </div> CORE_PM01_ARTHRITIS_ONSET 99 <input type="radio"/> Don't know CORE_PM01_ARTHRITIS_ONSET_CA



CORE_PM02_CANCER_OCCURRENCE

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

1 ☐ Yes

0 ☐ No

9 ☐ Don't know

→ SKIP TO PM04 (PAGE 17)

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

First type of Cancer

Cancer type	Age at first Diagnosis	Treatment	Type of treatment
CORE_PM03_CANCER_1_TYPE			
1 <input type="radio"/> Bladder	CORE_PM03_CANCER_1_AGE	CORE_PM03_CANCER_1_TX	
2 <input type="radio"/> Brain	<input type="text"/> <input type="text"/> Age at first diagnosis	Did you receive treatment for this cancer?	
3 <input type="radio"/> Breast	CORE_PM03_CANCER_1_AGE_CA		
4 <input type="radio"/> Cervix	<input type="radio"/> Don't know		
5 <input type="radio"/> Colon	99		
6 <input type="radio"/> Esophagus		1 <input type="radio"/> Yes →	What type of treatment was it?
7 <input type="radio"/> Kidney		0 <input type="radio"/> No	(Choose ALL that apply)
8 <input type="radio"/> Larynx		9 <input type="radio"/> Don't know	
9 <input type="radio"/> Leukemia			
10 <input type="radio"/> Liver	CORE_PM03_CANCER_1_TX_TYPE_CHEMO		<input type="radio"/> Chemotherapy
11 <input type="radio"/> Lung and Bronchus	CORE_PM03_CANCER_1_TX_TYPE_RAD		<input type="radio"/> Radiation
12 <input type="radio"/> Lymphoma	CORE_PM03_CANCER_1_TX_TYPE_SURG		<input type="radio"/> Surgery
13 <input type="radio"/> Non-Hodgkin Lymphoma	CORE_PM03_CANCER_1_TX_TYPE_OTHER		<input type="radio"/> Other (Please specify):
14 <input type="radio"/> Ovary	CORE_PM03_CANCER_1_TX_OTHER		<input type="text"/>
15 <input type="radio"/> Pancreas			
16 <input type="radio"/> Prostate	CORE_PM03_CANCER_1_TX_TYPE_DK		<input type="radio"/> Don't know
17 <input type="radio"/> Rectum			
18 <input type="radio"/> Skin			
19 <input type="radio"/> Stomach			
20 <input type="radio"/> Thyroid			
21 <input type="radio"/> Trachea			
22 <input type="radio"/> Uterus			
23 <input type="radio"/> Other (Please specify):			
<input type="text"/>	CORE_PM03_CANCER_1_OTHER_TYPE		
99 <input type="radio"/> Don't know			

888 ○ Not Applicable - I have only been diagnosed with one type of cancer.

SKIP TO PM04 (PAGE 17)

Second type of Cancer

Cancer type	Age at first Diagnosis	Treatment	Type of treatment
CORE_PM03_CANCER_2_TYPE			
1 ○ Bladder	CORE_PM03_CANCER_2_AGE	CORE_PM03_CANCER_2_TX	
2 ○ Brain	<input type="text"/> <input type="text"/> Age at first diagnosis	Did you receive treatment for this cancer?	
3 ○ Breast	CORE_PM03_CANCER_2_AGE_CA		
4 ○ Cervix	99 ○ Don't know		
5 ○ Colon			
6 ○ Esophagus		1 ○ Yes →	What type of treatment was it?
7 ○ Kidney		0 ○ No	
8 ○ Larynx		9 ○ Don't know	(Choose ALL that apply)
9 ○ Leukemia			
10 ○ Liver	CORE_PM03_CANCER_2_TX_TYPE_CHEMO		○ Chemotherapy
11 ○ Lung and Bronchus	CORE_PM03_CANCER_2_TX_TYPE_RAD		○ Radiation
12 ○ Lymphoma	CORE_PM03_CANCER_2_TX_TYPE_SURG		○ Surgery
13 ○ Non-Hodgkin Lymphoma	CORE_PM03_CANCER_2_TX_TYPE_OTHER		○ Other (Please specify):
14 ○ Ovary	CORE_PM03_CANCER_2_TX_OTHER		<input type="text"/>
15 ○ Pancreas	CORE_PM03_CANCER_2_TX_TYPE_DK		○ Don't know
16 ○ Prostate			
17 ○ Rectum			
18 ○ Skin			
19 ○ Stomach			
20 ○ Thyroid			
21 ○ Trachea			
22 ○ Uterus			
23 ○ Other (Please specify):	CORE_PM03_CANCER_2_OTHER_TYPE		
<input type="text"/>			
99 ○ Don't know			

888 ☐ Not Applicable - I have only been diagnosed with two types of cancer.

SKIP TO PM04 (NEXT PAGE)

Third type of Cancer

	Cancer type CORE_PM03_CANCER_3_TYPE	Age at first Diagnosis CORE_PM03_CANCER_3_AGE Age at first diagnosis CORE_PM03_CANCER_3_AGE_CA <input type="radio"/> Don't know	Treatment CORE_PM03_CANCER_3_TX Did you receive treatment for this cancer? <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	Type of treatment What type of treatment was it? (Choose ALL that apply) <input type="radio"/> Chemotherapy <input type="radio"/> Radiation <input type="radio"/> Surgery <input type="radio"/> Other (Please specify): <input type="text"/> <input type="radio"/> Don't know
1	<input type="radio"/> Bladder			
2	<input type="radio"/> Brain			
3	<input type="radio"/> Breast			
4	<input type="radio"/> Cervix			
5	<input type="radio"/> Colon			
6	<input type="radio"/> Esophagus			
7	<input type="radio"/> Kidney			
8	<input type="radio"/> Larynx			
9	<input type="radio"/> Leukemia			
10	<input type="radio"/> Liver			
11	<input type="radio"/> Lung and Bronchus			
12	<input type="radio"/> Lymphoma			
13	<input type="radio"/> Non-Hodgkin Lymphoma			
14	<input type="radio"/> Ovary			
15	<input type="radio"/> Pancreas			
16	<input type="radio"/> Prostate			
17	<input type="radio"/> Rectum			
18	<input type="radio"/> Skin			
19	<input type="radio"/> Stomach			
20	<input type="radio"/> Thyroid			
21	<input type="radio"/> Trachea			
22	<input type="radio"/> Uterus			
23	<input type="radio"/> Other (Please specify): <input type="text"/>			
99	<input type="radio"/> Don't know			



CORE_PM04_OTHER_CONDITIONS

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

1 ☐ Yes

0 ☐ No

9 ☐ Don't know

SKIP TO PRESCRIBED MEDICATION - ME01 (NEXT PAGE)

Please list these long-term conditions.

Long term condition 1:

Long term condition 2:

Long term condition 3:

Long term condition 4:

Long term condition 5:

Long term condition 6:

Long term condition 7:

Long term condition 8:

Long term condition 9:

Long term condition 10:



PRESCRIBED MEDICATION

CORE_ME01_CURRENT_RX

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

1 ☐ Yes

0 ☐ No

9 ☐ Don't know

→
SKIP TO FAMILY HEALTH
HISTORY - FM01 (NEXT
PAGE)

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

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



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



FAMILY HEALTH HISTORY

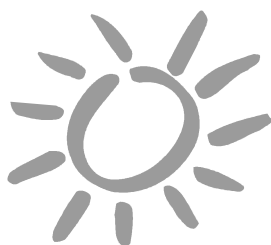
For your family health history, please **ONLY** include **immediate blood relatives**, including your mother, father, children, full and half brothers and sisters. Do not include relatives by marriage, stepbrothers and stepsisters, parents by adoption, stepchildren or adopted children.

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

	Health Condition		
Mother	Heart attack (myocardial infarction)	1 <input type="radio"/> Yes	0 <input type="radio"/> No 9 <input type="radio"/> Don't know
	Stroke	1 <input type="radio"/> Yes	0 <input type="radio"/> No 9 <input type="radio"/> Don't know
	Diabetes	1 <input type="radio"/> Yes	0 <input type="radio"/> No 9 <input type="radio"/> Don't know
	Chronic obstructive pulmonary disease	1 <input type="radio"/> Yes	0 <input type="radio"/> No 9 <input type="radio"/> Don't know
	High blood pressure	1 <input type="radio"/> Yes	0 <input type="radio"/> No 9 <input type="radio"/> Don't know
	Asthma	1 <input type="radio"/> Yes	0 <input type="radio"/> No 9 <input type="radio"/> Don't know
	Major depression	1 <input type="radio"/> Yes	0 <input type="radio"/> No 9 <input type="radio"/> Don't know
	Liver cirrhosis	1 <input type="radio"/> Yes	0 <input type="radio"/> No 9 <input type="radio"/> Don't know
	Chronic hepatitis	1 <input type="radio"/> Yes	0 <input type="radio"/> No 9 <input type="radio"/> Don't know
	Crohn's disease	1 <input type="radio"/> Yes	0 <input type="radio"/> No 9 <input type="radio"/> Don't know
	Ulcerative colitis	1 <input type="radio"/> Yes	0 <input type="radio"/> No 9 <input type="radio"/> Don't know
	Irritable bowel syndrome	1 <input type="radio"/> Yes	0 <input type="radio"/> No 9 <input type="radio"/> Don't know
	Eczema	1 <input type="radio"/> Yes	0 <input type="radio"/> No 9 <input type="radio"/> Don't know
	Lupus	1 <input type="radio"/> Yes	0 <input type="radio"/> No 9 <input type="radio"/> Don't know
	Psoriasis	1 <input type="radio"/> Yes	0 <input type="radio"/> No 9 <input type="radio"/> Don't know
	Multiple sclerosis	1 <input type="radio"/> Yes	0 <input type="radio"/> No 9 <input type="radio"/> Don't know
	Osteoporosis	1 <input type="radio"/> Yes	0 <input type="radio"/> No 9 <input type="radio"/> Don't know
Arthritis	1 <input type="radio"/> Yes	0 <input type="radio"/> No 9 <input type="radio"/> Don't know	



	Health Condition		
Father	Heart attack (myocardial infarction)	1	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	Stroke	1	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	Diabetes	1	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	Chronic obstructive pulmonary disease	1	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	High blood pressure	1	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	Asthma	1	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	Major depression	1	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	Liver cirrhosis	1	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	Chronic hepatitis	1	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	Crohn's disease	1	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	Ulcerative colitis	1	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	Irritable bowel syndrome	1	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	Eczema	1	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	Lupus	1	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	Psoriasis	1	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	Multiple sclerosis	1	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	Osteoporosis	1	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
	Arthritis	1	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know



	Health Condition	Number of Siblings Diagnosed
Siblings <input type="radio"/> I do not have any siblings	Heart attack (myocardial infarction) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	Stroke <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	Diabetes <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	Chronic obstructive pulmonary disease <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	High blood pressure <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	Asthma <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	Major depression <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	Liver cirrhosis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	Chronic hepatitis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	Crohn's disease <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	Ulcerative colitis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	Irritable bowel syndrome <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	Eczema <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	Lupus <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	Psoriasis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	Multiple sclerosis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>
Arthritis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of siblings <input type="text"/> <input type="text"/>	



	Health Condition	Number of Children Diagnosed
Children <input type="radio"/> I do not have any children	Heart attack (myocardial infarction) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Stroke <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Diabetes <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Chronic obstructive pulmonary disease <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	High blood pressure <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Asthma <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Major depression <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Liver cirrhosis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Chronic hepatitis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Crohn's disease <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Ulcerative colitis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Irritable bowel syndrome <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Eczema <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Lupus <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Psoriasis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Multiple sclerosis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Osteoporosis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>
	Arthritis <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know	If yes, # of children <input type="text"/> <input type="text"/>



CORE_FM02_CANCER_FAMILY

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

1 ☐ Yes

0 ☐ No

9 ☐ Don't know

SKIP TO SLEEP PATTERN - SP01 (PAGE 28)

CORE_FM03_CANCER_M

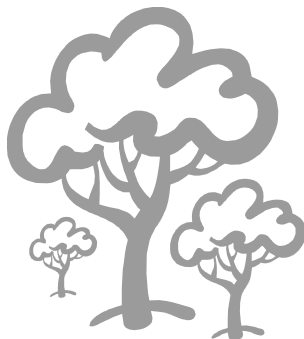
FM03 Has your **biological** mother ever been diagnosed with cancer?

1 ☐ Yes

0 ☐ No

9 ☐ Don't know

SKIP TO FM05 (NEXT PAGE)



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

- | | |
|---|---|
| <input type="radio"/> Bladder | <input type="radio"/> Non-Hodgkin Lymphoma |
| <input type="radio"/> Brain | <input type="radio"/> Ovary |
| <input type="radio"/> Breast | <input type="radio"/> Pancreas |
| <input type="radio"/> Cervix | <input type="radio"/> Rectum |
| <input type="radio"/> Colon | <input type="radio"/> Skin |
| <input type="radio"/> Esophagus | <input type="radio"/> Stomach |
| <input type="radio"/> Kidney | <input type="radio"/> Thyroid |
| <input type="radio"/> Larynx | <input type="radio"/> Trachea |
| <input type="radio"/> Leukemia | <input type="radio"/> Uterus |
| <input type="radio"/> Liver | <input type="radio"/> Other (Please specify): |
| <input type="radio"/> Lung and Bronchus | <input type="radio"/> Don't Know |
| <input type="radio"/> Lymphoma | |

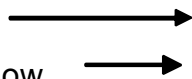
CORE_FM05_CANCER_F

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

1 ☐ Yes

0 ☐ No

9 ☐ Don't know



SKIP TO FM07 (NEXT PAGE)

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

- | | |
|---|---|
| <input type="radio"/> Bladder | <input type="radio"/> Lymphoma |
| <input type="radio"/> Brain | <input type="radio"/> Non-Hodgkin Lymphoma |
| <input type="radio"/> Breast | <input type="radio"/> Pancreas |
| <input type="radio"/> Colon | <input type="radio"/> Prostate |
| <input type="radio"/> Esophagus | <input type="radio"/> Rectum |
| <input type="radio"/> Kidney | <input type="radio"/> Skin |
| <input type="radio"/> Larynx | <input type="radio"/> Stomach |
| <input type="radio"/> Leukemia | <input type="radio"/> Thyroid |
| <input type="radio"/> Liver | <input type="radio"/> Trachea |
| <input type="radio"/> Lung and Bronchus | <input type="radio"/> Other (Please specify): |
| | <input type="radio"/> Don't Know |



CORE_FM07_CANCER_SIB

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

1 ☐ Yes



If yes, how many siblings?

CORE_FM07_CANCER_SIB_NUM

0 ☐ No

2 ☐ I do not have any siblings

9 ☐ Don't know

99 ☐ Don't know

CORE_FM07_CANCER_SIB_NUM_CA

CORE_FM08_CANCER_CHILD

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

1 ☐ Yes



If yes, how many children?

CORE_FM08_CANCER_CHILD_NUM

0 ☐ No

2 ☐ I do not have any children

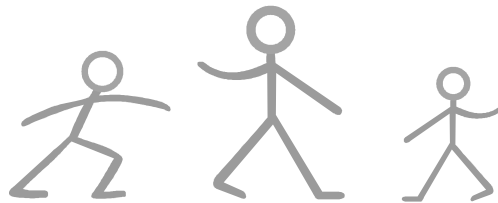
9 ☐ Don't know

99 ☐ Don't know

CORE_FM08_CANCER_CHILD_NUM_CA

IF "NO" FOR FM07 AND FM08 **OR**
IF "DO NOT HAVE ANY SIBLINGS AND CHILDREN" **OR**
IF "DON'T KNOW" FOR FM07 AND FM08

SKIP TO SLEEP PATTERN - SP01 (PAGE 28)



FM09 For your biological siblings and children, please indicate how many siblings and children have been diagnosed with the cancer types listed below. Leave blank if none of your siblings or children have been diagnosed with a particular type of cancer.

Cancer type	Number of siblings diagnosed	Number of children diagnosed
Bladder	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Brain	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Breast	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Cervix	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Colon	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Esophagus	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Kidney	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Larynx	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Leukemia	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Liver	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Lung and Bronchus	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Lymphoma	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Non-Hodgkin Lymphoma	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Ovary	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Pancreas	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Prostate	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Rectum	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children



Cancer type	Number of siblings diagnosed	Number of children diagnosed
Skin	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Stomach	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Thyroid	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Trachea	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Uterus	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children
Other	<input type="text"/> <input type="text"/> Number of siblings Please specify the cancer type <input type="text"/>	<input type="text"/> <input type="text"/> Number of children Please specify the cancer type <input type="text"/>
Don't Know	<input type="text"/> <input type="text"/> Number of siblings	<input type="text"/> <input type="text"/> Number of children



SLEEP PATTERN

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

CORE_SP01_SLEEP_TOTAL_HOURS

Hours **AND**

Minutes

CORE_SP01_SLEEP_TOTAL_MINUTES

9999 ☐ Don't know CORE_SP01_SLEEP_TOTAL_CA

CORE_SP02_SLEEP_TROUBLE

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

1 ☐ None of the time

2 ☐ A little of the time

3 ☐ Some of the time

4 ☐ Most of the time

0 ☐ All the time

9 ☐ Don't know

CORE_SP03_SLEEP_LIGHT

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

0 ☐ Virtually no light

1 ☐ Some light

2 ☐ A lot of light

9 ☐ Don't know



CORE_SU01_TANNING

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

- 0 ☐ Never
- 1 ☐ 1 to 4 times
- 2 ☐ 5 to 9 times
- 3 ☐ 10 to 14 times
- 4 ☐ 15 to 19 times
- 5 ☐ 20 to 24 times
- 6 ☐ 25 or more times
- 9 ☐ Don't know

CORE_SU02_BURNING

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

- 4 ☐ A severe sunburn with blisters
- 3 ☐ A severe sunburn for a few days with peeling
- 2 ☐ Mildly burnt with some tanning
- 1 ☐ Turning darker without sunburn
- 0 ☐ Nothing would happen in an hour
- 5 ☐ Other

CORE_SU03_HAIR

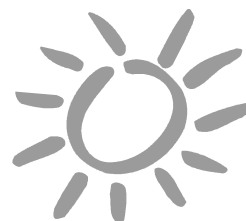
SU03 What is your natural hair colour? If your hair is now grey, please select the colour of your hair before it turned grey. (Choose **ONE** only)

- 1 ☐ Blonde
- 2 ☐ Red
- 3 ☐ Light brown
- 4 ☐ Dark brown
- 5 ☐ Black

CORE_SU04_EYES

SU04 What your natural eye colour? (Choose **ONE** only)

- 1 ☐ Amber
- 2 ☐ Blue
- 3 ☐ Brown
- 4 ☐ Grey
- 5 ☐ Green
- 6 ☐ Hazel
- 7 ☐ Red (Albino)



FOOD CONSUMED IN A TYPICAL DAY

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

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

CORE_FC01_VEG_DAY_NUM

Servings per day

CORE_FC01_VEG_DAY_NUM_Ca

1 ☐ None

99 ☐ Don't know

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

CORE_FC02_FRUIT_DAY_NUM

Servings per day

CORE_FC02_FRUIT_DAY_NUM_Ca

1 ☐ None

99 ☐ Don't know

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

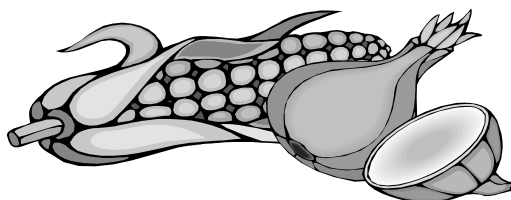
CORE_FC03_JUICE_DAY_NUM

Servings per day

CORE_FC03_JUICE_DAY_NUM_Ca

1 ☐ None

99 ☐ Don't know



ALCOHOL USE

CORE_AU01_ALCOHOL_EVER

AU01 Have you ever consumed alcohol?

1 ☐ Yes

0 ☐ No

9 ☐ Don't know

SKIP TO TOBACCO USE - TU01 (PAGE 33)

CORE_AU02_ALCOHOL_FREQ

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

7 ☐ 6 to 7 times a week

6 ☐ 4 to 5 times a week

5 ☐ 2 to 3 times a week

4 ☐ Once a week

3 ☐ 2 to 3 times a month

2 ☐ About once a month

1 ☐ Less than once a month

0 ☐ Never

9 ☐ Don't know

SKIP TO AU05 (NEXT PAGE)

SKIP TO TOBACCO USE - TU01 (PAGE 33)

AU03 On average, how many drinks do you have during a typical week?

A standard drink means one glass of wine or a wine cooler (142 ml, 5 ounces), one bottle or can of beer or a glass of draft (341 ml, 12 ounces), one straight or mixed drink with 1.5 ounces (43ml) of liquor.

Drink(s) per

week

CORE_AU03_RED_WINE_FREQ

Red Wine

--	--

CORE_AU03_RED_WINE_FREQ_Ca

1 ☐ None 99 ☐ Don't know

CORE_AU03_WHITE_WINE_FREQ

White Wine

--	--

CORE_AU03_WHITE_WINE_FREQ_Ca

1 ☐ None 99 ☐ Don't know

CORE_AU03_BEER_FREQ

Beer

--	--

CORE_AU03_BEER_FREQ_Ca

1 ☐ None 99 ☐ Don't know

CORE_AU03_LIQUOR_FREQ

Liquor/Spirits

--	--

CORE_AU03_LIQUOR_FREQ_Ca

1 ☐ None 99 ☐ Don't know

CORE_AU03_OTHER_ALC_FREQ

Other Alcohol

--	--

CORE_AU03_OTHER_ALC_FREQ_Ca

1 ☐ None 99 ☐ Don't know

CORE_AU04_ALCOHOL_DAYS

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

1 ☐ Yes

0 ☐ No

MEN ONLY, WOMEN SKIP TO AU06 (THIS PAGE)

CORE_AU05_BINGE_MALE

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

A standard drink means one glass of wine or a wine cooler (142 ml, 5 ounces), one bottle or can of beer or a glass of draft (341 ml, 12 ounces), one straight or mixed drink with 1.5 ounces (43ml) of liquor.

- 8 ○ 6 to 7 times a week
- 7 ○ 4 to 5 times a week
- 6 ○ 2 to 3 times a week
- 5 ○ Once a week
- 4 ○ 2 to 3 times a month
- 3 ○ About once a month
- 2 ○ 6 to 11 times a year
- 1 ○ 1 to 5 times a year
- 0 ○ Never
- 99 ○ Don't know

WOMEN ONLY, MEN SKIP TO TOBACCO USE - TU01 (NEXT PAGE)

CORE_AU06_BINGE_FEMALE

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

A standard drink means one glass of wine or a wine cooler (142 ml, 5 ounces), one bottle or can of beer or a glass of draft (341 ml, 12 ounces), one straight or mixed drink with 1.5 ounces (43ml) of liquor.

- 8 ○ 6 to 7 times a week
- 7 ○ 4 to 5 times a week
- 6 ○ 2 to 3 times a week
- 5 ○ Once a week
- 4 ○ 2 to 3 times a month
- 3 ○ About once a month
- 2 ○ 6 to 11 times a year
- 1 ○ 1 to 5 times a year
- 0 ○ Never
- 99 ○ Don't know



TOBACCO USE

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

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

CORE_TU01_EVER_SMOKED

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

1 ☐ Yes



SKIP TO TU03 (THIS PAGE)

0 ☐ No

9 ☐ Don't know

CORE_TU02_WHOLE_CIG

TU02 Have you ever smoked a whole cigarette?

1 ☐ Yes

0 ☐ No



SKIP TO TU16 (PAGE 35)

9 ☐ Don't know



CORE_TU03_WHOLE_CIG_AGE

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

Age

CORE_TU04_CURRENT_SMOKER

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

2 ☐ Daily (At least one cigarette every day for the past 30 days)



GO TO TU05 (THIS PAGE)

1 ☐ Occasionally (At least one cigarette in the past 30 days, but not every day)



GO TO TU09 (NEXT PAGE)

0 ☐ Not at all (You did not smoke at all in the past 30 days)



GO TO TU11 (NEXT PAGE)

CORE_TU05_DAILY_SMOKER_AGE

TU05 At what age did you begin smoking cigarettes daily?

Age

CORE_TU06_DAILY_SMOKER_QTY

TU06 How many cigarettes do you smoke each day now?

1 ☐ 1 - 5 cigarettes

4 ☐ 16 - 20 cigarettes

2 ☐ 6 - 10 cigarettes

5 ☐ 21 - 25 cigarettes

3 ☐ 11 - 15 cigarettes

6 ☐ 26+ cigarettes



If 26+, how many?

CORE_TU06_DAILY_SMOKER_NUM



CORE_TU07_DAILY_SMOKER_YRS

TU07 For how many total years have you smoked daily?

--	--

 Years

CORE_TU08_DAILY_SMOKER_YRS_QTY

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

1 ○ 1 - 5 cigarettes 4 ○ 16 - 20 cigarettes

2 ○ 6 - 10 cigarettes 5 ○ 21 - 25 cigarettes

3 ○ 11 - 15 cigarettes 6 ○ 26+ cigarettes →

If 26+, how many?

--	--

CORE_TU08_DAILY_SMOKER_AVG_NUM



If you currently smoke daily SKIP TO TU16 (NEXT PAGE)

CORE_TU09_OCC_SMOKER_FREQ

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

1 ○ 1 - 5 days 3 ○ 11 - 20 days

2 ○ 6 - 10 days 4 ○ 21 - 29 days

CORE_TU10_OCC_SMOKER_QTY

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

1 ○ 1 - 5 cigarettes 4 ○ 16 - 20 cigarettes

2 ○ 6 - 10 cigarettes 5 ○ 21 - 25 cigarettes

3 ○ 11 - 15 cigarettes 6 ○ 26+ cigarettes

CORE_TU11_OCC_SMOKER_DAILY

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

1 ○ Yes

2 ○ No

3 ○ Don't know



SKIP TO TU16 (NEXT PAGE)

CORE_TU12_OCC_SMOKER_AGE

TU12 At what age did you begin to smoke daily?

--	--

 Age

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

1 ☐ 1 - 5 cigarettes 4 ☐ 16 - 20 cigarettes

2 ☐ 6 - 10 cigarettes 5 ☐ 21 - 25 cigarettes

CORE_TU13_OCC_SMOKER_NUM

3 ☐ 11 - 15 cigarettes 6 ☐ 26+ cigarettes —————> If 26+, how many?

CORE_TU14_OCC_SMOKER_YRS

TU14 For how many total years did you smoke daily?

Years

CORE_TU15_OCC_SMOKER_AGE_STOP

TU15 When did you stop smoking cigarettes daily?

1 ☐ Less than 1 year ago 4 ☐ More than 5 years ago

2 ☐ 1 to 2 years ago 9 ☐ Don't know

3 ☐ 3 to 5 years ago

—————> **Everyone answers the last questions**

CORE_TU16_OTHER_TOBACCO

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

1 ☐ Yes

0 ☐ No

9 ☐ Don't know

—————> **SKIP TO ENVIRONMENTAL TOBACCO
SMOKE - ET01 (PAGE 37)**

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

Cigars CORE_TU17_CIGARS_EVER	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Small cigars (cigarillos)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Tobacco pipes CORE_TU17_PIPES_EVER	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Chewing tobacco or snuff	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Nicotine patches CORE_TU17_PATCH_EVER	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Nicotine gum CORE_TU17_GUM_EVER	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Betel nut CORE_TU17_BETEL_EVER	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Paan CORE_TU17_PAAN_EVER	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Sheesha CORE_TU17_SHEESHA_EVER	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Other, Please Specify <input type="text"/>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know

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

Cigars CORE_TU18_CIGARS_CUR	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Small cigars (cigarillos)	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Tobacco pipes CORE_TU18_PIPES_CUR	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Chewing tobacco or snuff	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Nicotine patches CORE_TU18_PATCH_CUR	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Nicotine gum CORE_TU18_GUM_CUR	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Betel nut CORE_TU18_BETEL_CUR	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Paan CORE_TU18_PAAN_CUR	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Sheesha CORE_TU18_SHEESHA_CUR	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know
Other, <div style="border: 1px solid black; display: inline-block; width: 150px; height: 20px; vertical-align: middle;"></div> Please specify	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Don't know



ENVIRONMENTAL TOBACCO SMOKE

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

Years
CORE_ET01_CHILD_HOME_ETS

1 ☐ None CORE_ET01_CHILD_HOME_ETS_Ca

99 ☐ Don't know

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

Years
CORE_ET02_ADULT_HOME_ETS

1 ☐ None CORE_ET02_ADULT_HOME_ETS_Ca

99 ☐ Don't know

CORE_ET03_HOME_ETS_FREQ

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

5 ☐ Every day

4 ☐ Almost every day

3 ☐ At least once a week

2 ☐ At least once a month

1 ☐ Less than once a month

0 ☐ Never

9 ☐ Don't know

CORE_ET04_LEISURE_ETS_FREQ

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

5 ☐ Every day

4 ☐ Almost every day

3 ☐ At least once a week

2 ☐ At least once a month

1 ☐ Less than once a month

0 ☐ Never

9 ☐ Don't know

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

Years
CORE_ET05_WORK_ETS

1 ☐ None CORE_ET05_WORK_ETS_Ca

99 ☐ Don't know



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

- 5 ☐ Every day
- 4 ☐ Almost every day
- 3 ☐ At least once a week
- 2 ☐ At least once a month
- 1 ☐ Less than once a month
- 0 ☐ Never
- 9 ☐ Don't know



PHYSICAL ACTIVITY

We are interested in finding out about the kinds of physical activities that people do as part of their everyday lives. The questions will ask you about the time you spent being physically active in the **last 7 days**. Please answer each question even if you do not consider yourself to be an active person. Please think about the activities you do at work, as part of your house and yard work, to get from place to place, and in your spare time for recreation, exercise or sport.

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

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

CORE_PA01_IPAQ_VIG_DAYS
days per week

CORE_PA01_IPAQ_VIG_NONE
1 ☐ No vigorous physical activities

→ SKIP TO PA03 (THIS PAGE)

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

CORE_PA02_IPAQ_VIG_TIME_HOURS hours per day **AND** CORE_PA02_IPAQ_VIG_TIME_MINUTES minutes per day

9999 ☐ Don't know/Not sure

CORE_PA02_IPAQ_VIG_TIME_Ca

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

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

CORE_PA03_IPAQ_MOD_DAYS
days per week

CORE_PA03_IPAQ_MOD_NONE
1 ☐ No moderate physical activities

→ SKIP TO PA05 (NEXT PAGE)

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

CORE_PA04_IPAQ_MOD_TIME_HOURS hours per day **AND** CORE_PA04_IPAQ_MOD_TIME_MINUTES minutes per day

9999 ☐ Don't know/Not sure

CORE_PA04_IPAQ_MOD_TIME_Ca



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

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

CORE_PA05_WALK_DAYS
days per week

1 ☐ No walking

→ SKIP TO PA07 (THIS PAGE)

CORE_PA05_WALK_NONE

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

CORE_PA06_WALK_TIME_HOURS

CORE_PA06_WALK_TIME_MINUTES

hours per day **AND** minutes per day

9999 ☐ Don't know/Not sure

CORE_PA06_WALK_TIME_Ca

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

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

CORE_PA07_WKDAY_SIT_HR

CORE_PA07_WKDAY_SIT_MIN

hours per day **AND** minutes per day

1 ☐ Don't know/Not sure

CORE_PA07_WKDAY_SIT_Ca

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

CORE_PA08_WKEND_SIT_HR

CORE_PA08_WKEND_SIT_MIN

hours per day **AND** minutes per day

☐ Don't know/Not sure

CORE_PA08_WKEND_SIT_Ca



ETHNIC BACKGROUND

EB01 What is your ethnic background and the ethnic background of your **biological** parents?
(Choose **ALL** that apply)

Ethnic background	You	Mother	Father
Aboriginal (e.g. First Nations, Métis, Inuit)	1 <input type="radio"/>	1 <input type="radio"/>	1 <input type="radio"/>
Arab (e.g. Egypt, Iraq, Jordan, Lebanon)	2 <input type="radio"/>	2 <input type="radio"/>	2 <input type="radio"/>
Black (e.g. African or Caribbean descent)	3 <input type="radio"/>	3 <input type="radio"/>	3 <input type="radio"/>
East Asian (e.g. China, Japan, Korea, Taiwan)	4 <input type="radio"/>	4 <input type="radio"/>	4 <input type="radio"/>
Filipino	5 <input type="radio"/>	5 <input type="radio"/>	5 <input type="radio"/>
Jewish	6 <input type="radio"/>	6 <input type="radio"/>	6 <input type="radio"/>
Latin American/Hispanic	7 <input type="radio"/>	7 <input type="radio"/>	7 <input type="radio"/>
South Asian (e.g. India, Sri Lanka, Pakistan, Bangladesh)	8 <input type="radio"/>	8 <input type="radio"/>	8 <input type="radio"/>
Southeast Asian (e.g. Malaysia, Indonesia, Viet Nam)	9 <input type="radio"/>	9 <input type="radio"/>	9 <input type="radio"/>
West Asian (e.g. Turkey, Iran, Afghanistan)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
White (European descent)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other ethnic group not listed above (please specify):	<input type="radio"/> Please specify: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<input type="radio"/> Please specify: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>	<input type="radio"/> Please specify: <div style="border: 1px solid black; height: 40px; width: 100%;"></div>
Don't know	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



EB02 In what country were you and your **biological** parents and grandparents born? (Choose only **ONE** per person)

Country of birth	You	Mother	Father	Mother's Mother	Mother's Father	Father's Mother	Father's Father
Canada	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
China	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
France	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Germany	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Greece	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
India	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Islamic Republic of Iran	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ireland	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Italy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Jamaica	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Republic of Korea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Philippines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poland	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Portugal	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Russian Federation	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ukraine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
United Kingdom	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
United States	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Viet Nam	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other country	<input type="radio"/> please specify <input type="text"/>	<input type="radio"/> please specify <input type="text"/>	<input type="radio"/> please specify <input type="text"/>	<input type="radio"/> please specify <input type="text"/>	<input type="radio"/> please specify <input type="text"/>	<input type="radio"/> please specify <input type="text"/>	<input type="radio"/> please specify <input type="text"/>
Don't know	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



IF YOU WERE BORN IN CANADA SKIP TO RESIDENCE - RE01 (THIS PAGE)

CORE_EB03_AGE_IMMIGRATION

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

Age when you first came to Canada to live

99 ○ Don't know CORE_EB03_AGE_IMMIGRATION_CA

RESIDENCE

RE01 In which city, town or village to you live?

RE02 What is your current postal code?

CORE_RE03_AGE_START_LIVING

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

Age when started living at current location

99 ○ Don't know CORE_RE03_AGE_START_LIVING_CA

CORE_RE04_CURR_RES_LONGEST

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

1 ○ Yes

0 ○ No

9 ○ Don't know



LANGUAGES

CORE_LS01_FIRST_LANG_

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

- | | |
|--|--|
| <input type="radio"/> English | <input type="radio"/> Italian |
| <input type="radio"/> French | <input type="radio"/> Korean |
| <input type="radio"/> Aboriginal Language(s) | <input type="radio"/> Mandarin |
| <input type="radio"/> Arabic | <input type="radio"/> Norwegian |
| <input type="radio"/> Bengali | <input type="radio"/> Polish |
| <input type="radio"/> Cantonese | <input type="radio"/> Portuguese |
| <input type="radio"/> Danish | <input type="radio"/> Punjabi |
| <input type="radio"/> Dutch | <input type="radio"/> Russian |
| <input type="radio"/> Farsi/Persian | <input type="radio"/> Spanish |
| <input type="radio"/> Finnish | <input type="radio"/> Swedish |
| <input type="radio"/> Gaelic | <input type="radio"/> Tagalog/Filipino |
| <input type="radio"/> German | <input type="radio"/> Tamil |
| <input type="radio"/> Greek | <input type="radio"/> Ukrainian |
| <input type="radio"/> Hindi | <input type="radio"/> Urdu |
| <input type="radio"/> Hungarian | <input type="radio"/> Vietnamese |
| <input type="radio"/> Icelandic | <input type="radio"/> Welsh |
| | <input type="radio"/> Other, please specify: |

CORE_LS01_FIRST_LANG_OTHER



WORKING STATUS

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

☐ Full-time employed/self-employed CORE_WS01_WORKING_STATUS_FT

☐ Part-time employed/self-employed CORE_WS01_WORKING_STATUS_PT

☐ Retired CORE_WS01_WORKING_STATUS_RETIRED

☐ Looking after home and/or family CORE_WS01_WORKING_STATUS_HOME

☐ Unable to work because of sickness or disability CORE_WS01_WORKING_STATUS_SICK

☐ Unemployed CORE_WS01_WORKING_STATUS_UNEMP

☐ Doing unpaid or voluntary work CORE_WS01_WORKING_STATUS_VOL

☐ Student CORE_WS01_WORKING_STATUS_STUDENT

IF EMPLOYED OR
SELF-EMPLOYED
(FULL-TIME OR PART-TIME),
GO TO WS02 (THIS PAGE),

OTHERWISE, SKIP TO WS07
(NEXT PAGE)

CORE_WS02_JOB_TITLE

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

☐ Don't know CORE_WS02_JOB_TITLE_CA

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

☐ Don't know

CORE_WS04_JOB_AGE_START

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

Age when you started working at current job

99 ☐ Don't know CORE_WS04_JOB_AGE_START_CA

CORE_WS05_JOB_SCHEDULE

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

1 ☐ Regular daytime schedule or shift

2 ☐ Regular evening shift

3 ☐ Regular night shift

4 ☐ Rotating shift, changing periodically from days to evenings or to nights

5 ☐ Split shift, consisting of two or more distinct periods each day

6 ☐ Irregular schedule, or on call

7 ☐ Other, Please specify

CORE_WS05_JOB_SCHED_TYPE



CORE_WS06_CURR_JOB_LONGEST

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

1 ☐ Yes →

SKIP TO HOUSEHOLD INCOME - HI01 (NEXT PAGE)

0 ☐ No

CORE_WS07

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

☐ Don't know

CORE_WS08

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

☐ Don't know

CORE_WS09_JOB_SCHED_LONGEST

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

1 ☐ Regular daytime schedule or shift

2 ☐ Regular evening shift

3 ☐ Regular night shift

4 ☐ Rotating shift, changing periodically from days to evenings or to nights

5 ☐ Split shift, consisting of two or more distinct periods each day

6 ☐ Irregular schedule, or on call

7 ☐ Other, Please specify

CORE_WS09_JOB_SCHED_LONG_TYPE

HOUSEHOLD INCOME

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

CORE_HI01_INCOME

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

- 1 ☐ Less than \$10,000
- 2 ☐ \$10,000 - \$24,999
- 3 ☐ \$25,000 - \$49,999
- 4 ☐ \$50,000 - \$74,999
- 5 ☐ \$75,000 - \$99,999
- 6 ☐ \$100,000 - \$149,999
- 7 ☐ \$150,000 - \$199,999
- 8 ☐ \$200,000 or more
- 99 ☐ Don't know
- 88 ☐ Prefer not to answer

CORE_HI02_NUM_SUPPORTED

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

Individuals

99 ☐ Don't know CORE_HI02_NUM_SUPPORTED_CA

CORE_HI03_ADULTS_HOME

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

Adults

CORE_HI04_CHILD_HOME

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

Children

ANTHROPOMETRIC MEASUREMENTS

CORE_AM01_HANDEDNESS

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

- 1 ☐ Left
- 2 ☐ Right
- 3 ☐ Ambidextrous

CORE_AM02_STAND

AM02 Are you able to stand without assistance?

- 1 ☐ Yes
- 0 ☐ No

IF you are UNABLE TO STAND WITHOUT ASSISTANCE,
this is the end of the questionnaire.
Thank you for taking the time to complete this survey.

Date of completion of the questionnaire:

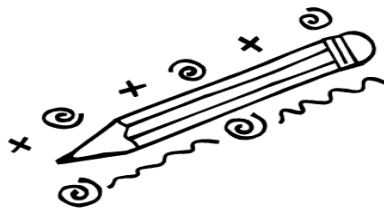
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ANTHROPOMETRIC MEASUREMENTS

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

Height

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

AM03 First Measurement feet inches **OR** centimetres
CORE_AVG_HEIGHT
AM04 Second Measurement feet inches **OR** centimetres

Weight

- Adjust your scale to zero;
- Weigh yourself with your clothes off, or wear light clothing. Remember to remove your shoes.
- Step on the scale. Make sure both feet are fully on the scale.
- Weigh yourself twice. The two weights should be within one pound (or a half kilogram) of each other. If not, weigh yourself a third time and record the closer of the two measurements.
- Record your weight in pounds or kilograms.



AM05 First Measurement pounds **OR** kilograms
CORE_AVG_WEIGHT
AM06 Second Measurement pounds **OR** kilograms



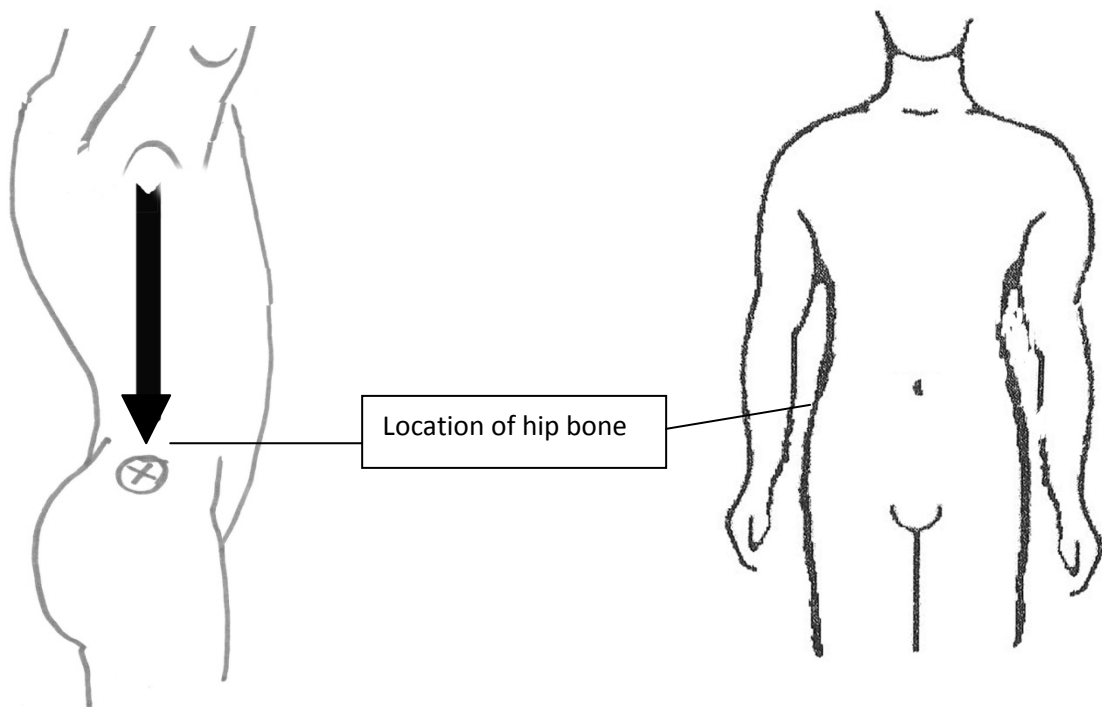
WAIST AND HIPS

Take the next set of measurements either unclothed or in tight fitting underwear.

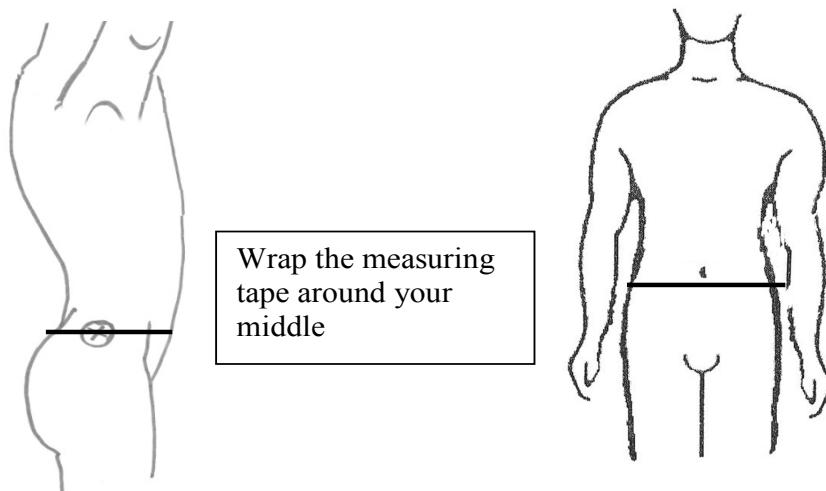
1. Stand in front of a mirror to help position the measuring tape correctly.
2. Pull the measuring tape tight enough that it does not slide, but not too tight to indent the skin;
3. Record the measurement in inches or centimetres.

Waist

- This measurement is taken at a specific spot found along your side. To find the spot simply place your thumb under your armpit, then slide your thumb straight down until you find the hip bone. (see diagram)



- Place your measuring tape over that spot where your thumb found the bone, then wrap the measuring tape around your middle.



- Look in the mirror and turn in a circle to ensure the measuring tape is level all around and not twisted at any point. Take the measurement, **EVEN IF THIS IS NOT YOUR USUAL WAISTLINE.**
- Measure twice. The two measurements should be within a half inch (or one centimetre) of each other. If they are not, take a third measurement and record the closest two measurements.
- Record your measurement to the nearest half inch or centimetre.

AM07 First Measurement inches **OR** centimetres

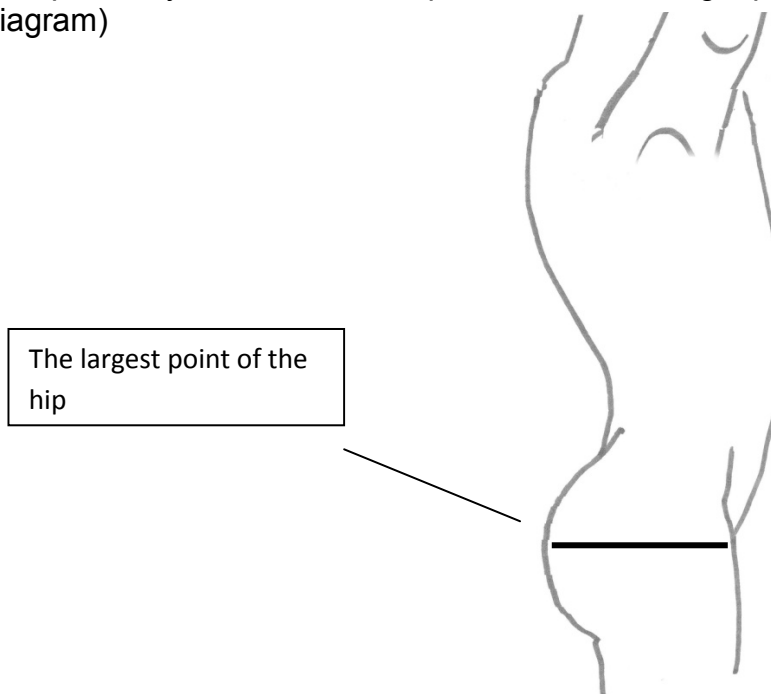
CORE_AVG ABDOMEN

AM08 Second Measurement inches **OR** centimetres



Hips

- Stand in profile to a mirror with your feet shoulder width apart.
- Look for the largest point of your buttocks and place the measuring tape at that position. (See diagram)



- Now turn in a full circle in front of the mirror to be certain the measuring tape is level all the way around your body. Take the measurement.
- Measure twice. The two measurements should be within a half inch (or one centimetre) of each other. If not, take a third measurement and record the closest two measurements.
- Record the size of your buttocks to the nearest half inch or centimetre.

AM09 First Measurement inches **OR** centimetres
CORE_AVG_HIP
AM10 Second Measurement inches **OR** centimetres

This is the end of the questionnaire!
Thank you for taking the time to complete this questionnaire.

