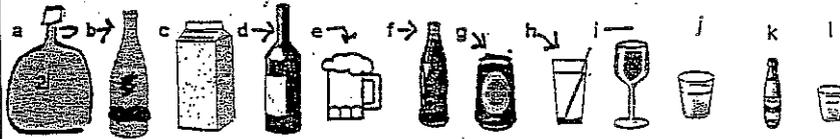


**MRC/NHLS/Wits CANCER EPIDEMIOLOGY RESEARCH GROUP (CERG)
JOHANNESBURG STUDY QUESTIONNAIRE FOR PATIENTS**

Date of Birth	OR	Age		Study No:																																																																															
Day	Month	Year		Sex (please tick)																																																																															
<input type="text"/>	<input type="text"/>	<input type="text" value="1"/> <input type="text" value="9"/>	<input type="text"/> Years	1 <input type="checkbox"/> M <input type="checkbox"/> F 2																																																																															
Diagnosis(Clinical)				Path No	<input type="text"/>																																																																														
Histology result, if available				Hospital No.	<input type="text"/>																																																																														
Initials of Interviewer			Date of Interview																																																																																
.....			Day	Month	Year																																																																														
			<input type="text"/>	<input type="text"/>	<input type="text" value="2"/> <input type="text" value="0"/>																																																																														
Where were you born? (please tick)																																																																																			
1 <input type="checkbox"/> Soweto 2 <input type="checkbox"/> Jhb 3 <input type="checkbox"/> Gauteng 4 <input type="checkbox"/> N.Prov. 5 <input type="checkbox"/> Mpum 6 <input type="checkbox"/> NW 7 <input type="checkbox"/> FS 8 <input type="checkbox"/> ECape																																																																																			
9 <input type="checkbox"/> W.Cape 10 <input type="checkbox"/> N.Cape 11 <input type="checkbox"/> Kwazulu Natal 12. Other																																																																																			
1 <input type="checkbox"/> Urban 2 <input type="checkbox"/> Rural																																																																																			
Where do you normally live? (please tick)																																																																																			
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1 <input type="checkbox"/> Urban 2 <input type="checkbox"/> Rural																																																																																			
How long have you lived there? <input type="text"/> Years																																																																																			
What is the highest standard you passed at school? (please tick)																																																																																			
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td colspan="10"></td> <td>Gr10</td> <td>Gr11</td> <td>Gr12</td> <td colspan="2"></td> </tr> <tr> <td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td><td>10</td> <td>11</td><td>12</td><td>13</td><td>14</td><td colspan="2"></td> </tr> <tr> <td>None</td><td>Sub A</td><td>Sub B</td><td>Std 1</td><td>Std 2</td><td>Std 3</td><td>Std 4</td><td>Std 5</td><td>Std 6</td><td>Std 7</td> <td>Std 8</td><td>Std 9</td><td>Std 10</td><td>Univ</td><td colspan="2">tech</td> </tr> <tr> <td></td><td>Gr1</td><td>Gr2</td><td>Gr3</td><td>Gr4</td><td>Gr5</td><td>Gr6</td><td>Gr7</td><td>Gr8</td><td>Gr9</td> <td>Form 3</td><td>Form 4</td><td>Form 5</td><td></td><td colspan="2"></td> </tr> <tr> <td colspan="10"></td> <td>NTC1</td><td>NTC2</td><td>NTC3</td><td colspan="2"></td> </tr> </table>																Gr10	Gr11	Gr12			1	2	3	4	5	6	7	8	9	10	11	12	13	14			None	Sub A	Sub B	Std 1	Std 2	Std 3	Std 4	Std 5	Std 6	Std 7	Std 8	Std 9	Std 10	Univ	tech			Gr1	Gr2	Gr3	Gr4	Gr5	Gr6	Gr7	Gr8	Gr9	Form 3	Form 4	Form 5														NTC1	NTC2	NTC3		
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										NTC1	NTC2	NTC3																																																																							
What are the walls of your home made of? (please tick)																																																																																			
1. brick/cement 2. Tin 3. Plastic 4. Wood 5. Other (specify) 6. mud/clay																																																																																			
Where do you normally cook food in your house? 1 <input type="checkbox"/> Inside <input type="checkbox"/> Outside 2																																																																																			
What type of fuel do you MOSTLY use in your home for cooking? (please tick)																																																																																			
1. Wood 2. Charcoal 3. Coal 4. Anthracite 5. Paraffin 6. Gas 7. Electricity 8. Other 9. dung																																																																																			
What type of fuel do you MOSTLY use in your home for keeping warm? (please tick)																																																																																			
1. Wood 2. Charcoal 3. Coal 4. Anthracite 5. Paraffin 6. Gas 7. Electricity 8. Other 9. dung 10. no fuel																																																																																			
Where did you normally cook food in your house 20 years ago? 1 <input type="checkbox"/> Inside <input type="checkbox"/> Outside 2																																																																																			
What type of fuel did you MOSTLY use in your home for cooking 20 years ago?																																																																																			
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In any of the houses you lived in, did the smoke ever make your eyes water?																																																																																			
1 <input type="checkbox"/> Yes, more than 5 years <input type="checkbox"/> No 2																																																																																			
Have you ever smoked cigarettes or a pipe regularly? (please tick) 1. Yes(now) 2. In the past 3. Never																																																																																			
If yes: In the past five to ten years, how many would you usually smoke in a day?																																																																																			
<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>1. Cigarettes</td> <td>2. Hand rolled cigarettes</td> <td>3. Pipes</td> <td>4. Dagga</td> </tr> <tr> <td>(number of)</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </table>						1. Cigarettes	2. Hand rolled cigarettes	3. Pipes	4. Dagga	(number of)	<input type="text"/>	<input type="text"/>	<input type="text"/>																																																																						
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(number of)	<input type="text"/>	<input type="text"/>	<input type="text"/>																																																																																
How old were you when you first started smoking regularly? <input type="text"/> Years old																																																																																			
If you have stopped smoking, how old were you when you stopped? <input type="text"/> Years old																																																																																			
Have you ever used snuff? (please tick) 1. Yes(now) 2. In the past 3. Never																																																																																			
In the past five to ten years, how often would you use snuff each day? <input type="text"/> times per day																																																																																			
Before you became ill, did you ever have your blood pressure measured? (Please tick)																																																																																			
1. Yes 2. No 3. Yes only during pregnancy																																																																																			
If yes, were you told it was high? (Please tick)																																																																																			
1. Yes 2. No 3. Yes only during pregnancy																																																																																			
Have you ever had diabetes? (Please tick) 1. Yes 2. No																																																																																			

Before you became ill, about how much wine, beer or spirits did you drink on average each week?
 (Please indicate glass/bottle size when you select block for each type of drink - eg. 3 large glasses of
 maize beer per week would be 3 e if none then 0

BEER		SPIRITS		WINE	CIDER; other	OTHER
sorghum (cartoon)	homemade (specify type)	commercial	Homemade	commercial	commercial alcoholic fruit drinks	SPECIFY



- a: 2l (wine bottle)
- b: bottle (1 litre)
- c: 1l carton
- d: 750ml (wine bottle)
- e: 500ml (beer glass)
- f: 375ml (half
jack/pint)
- g: 340ml (beer
can/dumpy)
- h: 250ml glass
- i: 200ml (wine
glass/nip)
- j: 100ml (small
glass)
- k: 50ml (miniature
airplane bottle)
- l: 25ml (tot)
mother (please
specify)

Are you? (please tick)

1. Single (never been married) 2. Married (living as married) 3. Widowed 4. Separated

How many husbands/wives have you had?

FOR WOMEN ONLY: Have you ever been pregnant? (please tick) 1. Yes 2. No

If yes, how many times have you been pregnant?

If yes, how many times have you had a miscarriage?

If yes, how many of your children were born alive?

FOR MEN ONLY: How many children (dead or alive) do you have?

ALL: How many mothers / fathers do the children have?

ALL: How old is your oldest child now? (include dead & alive) Years old

ALL: How old is your youngest child now? (include dead & alive) Years old

ALL: How many boyfriends/girlfriends have you had?

FOR WOMEN ONLY
How old were you when your periods began? Years old

Have your periods ended? Yes 1 No 2 Not sure 3 If yes, how old were you when they ended? years old

If Yes, did your periods stop?

1. naturally 2. due to surgery 3. due to medical treatment 4. due to IC use 5. other 6. unknown

	Oral	Injectable
Have you ever taken contraceptives?	1. <input type="checkbox"/> Yes <input type="checkbox"/> No	2. 1. <input type="checkbox"/> Yes <input type="checkbox"/> No 2.
If yes, how old were you when you started taking them?	<input type="text"/> <input type="text"/> Years old	<input type="text"/> <input type="text"/> Years old
How old were you when you stopped taking them?	<input type="text"/> <input type="text"/> Years old	<input type="text"/> <input type="text"/> Years old
If yes, for how long in total did you take them?	<input type="text"/> <input type="text"/> Years	<input type="text"/> <input type="text"/> Years
Interruptions? <input checked="" type="checkbox"/>	1. <input type="checkbox"/> Yes <input type="checkbox"/> No 2.	1. <input type="checkbox"/> Yes <input type="checkbox"/> No 2.

Main reason for stopping, the last time you stopped using the method:

1. Nausea 2. high BP 3. headaches 4. wt. Gain 5. changed menstrual pattern 6. menopause 7. sterilization 8. hysterectomy 9. no partner
 10. to become pregnant 11. other 12. no specific reason.

Have you ever had a 'pap' smear?

0. Never	1. Yes	2. current illness only	9. Can't remember	If yes, how many?	Age at first pap (yrs)	Age at last pap (yrs)
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FOR ALL: Describe your usual or past occupation (eg. Driver, machine operator).....

Describe what your usual workplace does or did (eg. A bank, a chemical factory, a gold mine).....

What language do you speak most at home?

What language does/did your father speak?

What language does/did your mother speak?

1. Zulu 2. Xhosa 3. Sotho 4. Pedi 5. Tswana 6. Vgnda 7. Swazi 8. Shangaan 9. Ndebele
 10. English 11. Afrikaans 12. Other