Data Collection Questionnaire

1. LAST NAME: [Blank] (Cols. 1-13)
2. FIRST NAME: [Blank] (Cols. 14-21)
3. MIDDLE INITIAL: [Blank] (Col. 22)
4. MAIDEN NAME: [Blank] (Cols. 23-35)
5. TELEPHONE: [Blank]
6. ADDRESS: [Blank] (Cols. 36-40)

7. ZIP CODE: [Blank]

RACE: W____ B____ O____ SEX: M____ F____ BIRTHDATE: Month___ Day___ Year___

MARITAL STATUS: Never married _____ Married now_____ Other_____ How tall are you? _____ft. _____in. How much do you weigh now? _____ At age 21? _____

Have you ever smoked cigarettes? _____ Yes/No _____
Do you now smoke cigarettes? _____ Yes/No _____
How many cigarettes do or did you smoke a day? _____ Cigarettes
Have you ever smoked cigars or a pipe? _____ Yes/No _____
Do you now smoke cigars or a pipe? _____ Yes/No _____
How many grades of school, including college, have you completed? _____ Grades

Are you under treatment for high blood pressure? _____ Yes/No _____
Are you under treatment for high cholesterol? _____ Yes/No _____
How many hours has it been since your last meal? _____ Hours

Have you ever had cancer? _____ Yes/No _____
Which organ? [Blank]
Where diagnosed? [Blank] In 19____
L.M.P. _____ days
O.C. _____ years
O.H. _____ years
O.M. 1. [Blank]
2. [Blank]
3. [Blank]
4. [Blank]
5. [Blank]

BP _____/_____ Code [Blank]
Hour AP Code [Blank]
Date [Blank]

THANK YOU. PLEASE HAND THIS FORM TO THE NURSE.
"To find out if certain substances in blood appear before the onset of cancer and other important diseases, it is necessary to obtain less than an ounce of blood from as many persons as possible in Washington County, MD. The blood components will be separated and stored in a freezer, to be withdrawn at a later date as needed for appropriate tests. Blood drawing is sometimes associated with bruising or pain at the site from which blood is drawn, as well as occasional lightheadedness, and rarely, fainting.

"The information from these tests will be used only for medical research. No results or other information will be released that identify any individual person.

"I hereby consent to having less than an ounce taken from my arm and used for the above purposes."

Signed _______________________________________________

Date _______________________________________________

"I hereby give my consent to having less than an ounce of blood taken from the arm of _______________________________________________."

Signed _______________________________________________

Parent ________ Legal Guardian ________

Date _______________________________________________