St. Jude Children's Research Hospital
ALSAC • Danny Thomas, Founder
Finding cures. Saving children.

SJLIFE
Abbreviated Survey

Finding cures. Saving children.

The questions in this booklet relate to:

Person completing this questionnaire is:

Your relationship:

☐ Self ☐ Parent ☐ Other: _____

Today's date: ☐☐ / ☐☐ / ☐☐☐☐
m m d d y y y y

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Please! Do not mark below this line

Survey #096

7478249113

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INSTRUCTIONS FOR COMPLETING THE QUESTIONNAIRE

Please follow these rules in completing this questionnaire. If you have any questions about completing this questionnaire, please call 1-800-775-2167.

1. Use a black ballpoint pen or a number 2 black pencil. Do not use a felt-tip or roller-ball pen. These may cause smudging.
2. When marking boxes, make an x inside the box (see examples below).
3. Make no stray marks of any kind. Please keep the form as clean as possible.
4. Written responses must stay within the boxes provided:

CORRECT

Grape

INCORRECT

MARKING EXAMPLES

Below are some examples of how to fill out this questionnaire. Please look these over before you begin.

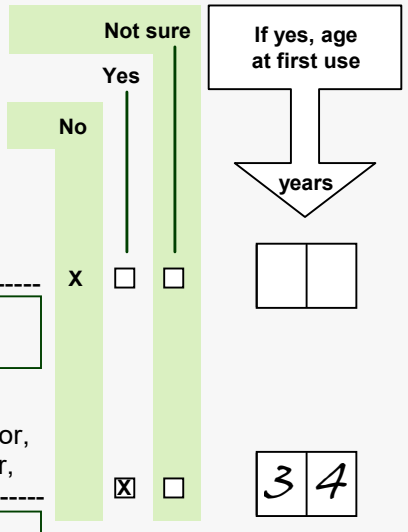
EXAMPLE 1

1. During the past month, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, bicycling, swimming, wheelchair basketball, or walking for exercise?

☐ No ☒ Yes

EXAMPLE 2

2. Have you ever taken. . .



a. BIRTH CONTROL PILLS such as Demulen, Lo-Ovral, Loestrin, Norinyl, Norplant, Ortho-Novum, Ovral, Triphasil----------

If yes, specify the name of the drug(s) or indicate you do not know the specific name

b. MEDICATIONS TO LOWER CHOLESTEROL OR TRIGLYCERIDES, such as Zocor, Pravachol, Lipitor, Colestid (colestipol), Tricor, Lescol, Lopid (gemfibrozil), Mevacor, niacin, or Lorelco----------

If yes, specify the name of the drug(s) or indicate you do not know the specific name

mevacor

EXAMPLE 3

3. When was this condition diagnosed?

0	4		1	9	9	5

Month (mm) Year (yyyy)

Please! Do not mark below this line

Medical Care

The next questions are about health care received since your last St. Jude Life visit.

A1. Since your last St. Jude Life visit, which of the following health care providers (excluding dentists) did you see or talk to for medical care?
(Mark all that apply)

- ☐ None → *Go to Question A7, next page.*
- ☐ Physician (including Osteopath)
- ☐ Nurse Practitioner/Physician's Assistant
- ☐ Nurse
- ☐ Chiropractor
- ☐ Physical Therapist
- ☐ Psychologist or psychiatrist
- ☐ Other

Specify

A2. Where did you receive your health care?
(Mark all that apply)

- ☐ Doctor's office
- ☐ Oncology (cancer) center or clinic
- ☐ Other type of clinic
- ☐ Hospital
- ☐ Emergency Room or Urgent Care Center
- ☐ Long-term follow-up clinic
- ☐ Other

Specify

A3. Since your last St. Jude Life visit, how many times did you see a physician?

- ☐ 0 times → *Go to Question A5a.*
- ☐ 1 - 2 times
- ☐ 3 - 4 times
- ☐ 5 - 6 times
- ☐ 7 - 10 times
- ☐ 11 - 20 times
- ☐ More than 20 times

A4. How many of the visits to the physician indicated in question A3 were related to this previous illness?

- ☐ 0 visits
- ☐ 1 - 2 visits
- ☐ 3 - 4 visits
- ☐ 5 - 6 visits
- ☐ 7 - 10 visits
- ☐ 11 - 20 visits
- ☐ More than 20 visits

A5a. Since your last St. Jude Life visit, how often did you telephone a doctor's office, regarding an illness or a medical condition you may have had?

- ☐ 0 times
- ☐ 1 - 2 times
- ☐ 3 - 4 times
- ☐ 5 - 6 times
- ☐ 7 - 10 times
- ☐ 11 - 20 times
- ☐ More than 20 times

A5b. Of these telephone contacts, how many were to St. Jude?

☐☐

A6. Since your last St. Jude Life visit, how many times were you admitted to any hospital?

☐☐

Please! Do not mark below this line

A7. Please indicate all medicines/drugs you took *regularly* since your last St. Jude Life visit.

- We are only asking about medicines/drugs which you took consistently for more than one month, or for 30 days or more in a year.

- Please list only drugs prescribed by a doctor and filled by a pharmacist. Include pills, syrups, injections, patches, or creams.

- Please do NOT include medicines/drugs that you bought without a prescription (over-the-counter drugs).

	No	Yes	Not sure	If yes, age at first use	If yes, are you currently taking any of these? No	If yes, are you currently taking any of these? Yes
1. BIRTH CONTROL MEDICATIONS such as Demulen, Lo-Ovral, Loestrin, Norinyl, Norplant, Ortho-Novum, Ovral, Triphasil, Depo Provera ----------	☐	☐	☐	years ☐☐	☐	☐
If yes, specify the name of the drug(s) or indicate you do not know the specific name						
2. ESTROGENS OR PROGESTERONES (FEMALE HORMONES) such as Estrace, Estraderm, Premarin, Provera, Medroxyprogesterone, Vivelle-------	☐	☐	☐	☐☐	☐	☐
If yes, specify the name of the drug(s) or indicate you do not know the specific name						
3. TESTOSTERONES (MALE HORMONES) such as Androgel, Delatesteral, Testosterone cypionate, Testosterone enanthate----------	☐	☐	☐	☐☐	☐	☐
If yes, specify the name of the drug(s) or indicate you do not know the specific name						
4. PILLS OR INSULIN FOR DIABETES such as Glucophage (metformin), Glucotrol (glipizide), Glynase (glyburide), Prandin, Amaryl, Avandia, Actos, or insulin injections (such as Humulin, Novolin, Lantus)----------	☐	☐	☐	☐☐	☐	☐
If yes, specify the name of the drug(s) or indicate you do not know the specific name						
5. MEDICATIONS FOR HIGH BLOOD PRESSURE OR HYPERTENSION such as hydrochlorothiazide (HCTZ), Dyazide (triamterene/HCTZ), Tenormin (atenolol), Lopressor (metoprolol), Zestril or Prinivil (lisinopril), Vasotec (enalapril), Cozaar, Hyzaar, Diovan, or others----------	☐	☐	☐	☐☐	☐	☐
If yes, specify the name of the drug(s) or indicate you do not know the specific name						

Please! Do not mark below this line

A7. (Cont)Please indicate all medicines/drugs you took *regularly* since your last St. Jude Life visit.

- We are only asking about medicines/drugs which you took consistently for more than one month, or for 30 days or more in a year.

- Please list only drugs prescribed by a doctor and filled by a pharmacist. Include pills, syrups, injections, patches, or creams.

- Please do NOT include medicines/drugs that you bought without a prescription (over-the-counter drugs).

	No	Yes	Not sure	If yes, age at first use	If yes, are you currently taking any of these? No	If yes, are you currently taking any of these? Yes
6. MEDICATIONS TO LOWER CHOLESTEROL OR TRIGLYCERIDES such as Lovastatin, Zocor (simvastatin), Pravachol (pravastatin), Crestor, Lipitor, Zetia, Tricor, Vytorin, gemfibrozil----------	☐	☐	☐	☐☐ years	☐	☐
If yes, specify the name of the drug(s) or indicate you do not know the specific name						
7. MEDICATIONS FOR HEART CONDITIONS, INCLUDING ANGINA, CORONARY ARTERY DISEASE, CONGESTIVE HEART FAILURE, OR IRREGULAR HEART BEAT----------	☐	☐	☐	☐☐	☐	☐
If yes, specify the name of the drug(s) or indicate you do not know the specific name						
8. THYROID MEDICATIONS such as Synthroid (levothyroxine or L-thyroxine), Levothroid, or others----------	☐	☐	☐	☐☐	☐	☐
If yes, specify the name of the drug(s) or indicate you do not know the specific name						
9. MEDICATIONS FOR DEPRESSION such as Prozac (fluoxetine), Serzone, Celexa, Zoloft, Wellbutrin, Effexor, Desyrel (trazodone), or Vivactil----------	☐	☐	☐	☐☐	☐	☐
If yes, specify the name of the drug(s) or indicate you do not know the specific name						
10. MEDICATIONS FOR TREATMENT OF LOW BONE MINERAL DENSITY (OSTEOPOROSIS/OSTEOPENIA) such as Fosamax (alendronate), Boniva (ibandronate), Actonel (risedronate), or Evista (Raloxifene)----------	☐	☐	☐	☐☐	☐	☐
If yes, specify the name of the drug(s) or indicate you do not know the specific name						

Please! Do not mark below this line

A7. (Cont)Please indicate all medicines/drugs you took *regularly* since your last St. Jude Life visit.

- We are only asking about medicines/drugs which you took consistently for more than one month, or for 30 days or more in a year.

- Please list only drugs prescribed by a doctor and filled by a pharmacist. Include pills, syrups, injections, patches, or creams.

- Please do NOT include medicines/drugs that you bought without a prescription (over-the-counter drugs).

	No	Yes	Not sure	If yes, age at first use	If yes, are you currently taking any of these? No	If yes, are you currently taking any of these? Yes
11. MEDICATIONS TO CORRECT LOW BLOOD LEVELS OF POTASSIUM, MAGNESIUM, PHOSPHOROUS, OR BICARBONATE such as KCl, KPhos, NeutraPhos, or Bicitra----------	☐	☐	☐	years	☐	☐
12. OTHER PRESCRIBED DRUGS----------	☐	☐	☐		☐	☐

If yes, specify the name of the drug(s) or indicate you do not know the specific name

If yes, specify the name of the drug(s) or indicate you do not know the specific name ***and*** specify the reason the drug was prescribed.

A8. Please list all over the counter medications (<u>NOT</u> prescribed by a doctor) which you took *regularly* since your last St. Jude Life visit.
We are only asking about medications which you took consistently for more than one month, or for 30 days or more in a year. Include pills, syrups, injections, patches, or creams.

A9. Please list all supplements which you took *regularly* since your last St. Jude Life visit.
We are only asking about medicines which you took consistently for more than one month, or for 30 days or more in a year. Include pills, syrups, injections, patches, or creams.

Please! Do not mark below this line

OFFSPRING/PREGNANCY HISTORY

B1. Have you or your partner had:
(Mark all that apply)

☐ A vasectomy → ***At what age?*** ☐☐

☐ A tubal ligation → ***At what age?*** ☐☐

B2. Are you, or your partner, currently pregnant?

☐ No

☐ Yes

B3. Since your last visit, was there a period when you and a partner tried to become pregnant, without success?

☐ No

☐ Yes

B4. Since your last visit, have you and a partner become pregnant?

☐ No → ***Go to Question C1.***

☐ Yes

B5. Including live births, stillbirths, miscarriages, and abortions, how many times have you become pregnant or had a woman become pregnant by you since your last visit?

☐☐ **times**

B6. Please fill in the following information for each of your pregnancies, or each time a woman has become pregnant by you, since your last visit, regardless of the outcome.

	Pregnancy outcome: Live birth	Stillbirth	Miscarriage	Medical abortion	Your age at start of pregnancy	Partner's age at start of pregnancy	Weeks pregnancy lasted
Pregnancy 1. .	☐	☐	☐	☐	☐☐	☐☐	☐☐
Pregnancy 2. .	☐	☐	☐	☐	☐☐	☐☐	☐☐
Pregnancy 3. .	☐	☐	☐	☐	☐☐	☐☐	☐☐
Pregnancy 4. .	☐	☐	☐	☐	☐☐	☐☐	☐☐
Pregnancy 5. .	☐	☐	☐	☐	☐☐	☐☐	☐☐

Please attach a separate sheet of paper, if more than 5 pregnancies

HEALTH HABITS

C1. In general, would you say your health is:

☐ Excellent

☐ Very good

☐ Good

☐ Fair

☐ Poor

C2. Compared to one year ago, how would you rate your health in general now?

☐ Much better now than one year ago

☐ Somewhat better now than one year ago

☐ About the same as one year ago

☐ Somewhat worse now than one year ago

☐ Much worse now than one year ago

Please! Do not mark below this line

C3. The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

	No, not limited at all	Yes, limited a little	Yes, limited a lot
a. Vigorous Activities, such as running, lifting heavy objects, participating in strenuous sports	☐	☐	☐
b. Moderate Activities, such as moving a table, bowling, or playing golf	☐	☐	☐
c. Lifting or carrying groceries	☐	☐	☐
d. Climbing several flights of stairs	☐	☐	☐
e. Climbing one flight of stairs	☐	☐	☐
f. Bending, kneeling, or stooping	☐	☐	☐
g. Walking more than a mile	☐	☐	☐
h. Walking several hundred yards	☐	☐	☐
i. Walking one hundred yards	☐	☐	☐
j. Bathing or dressing yourself	☐	☐	☐

C4. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
a. Cut down on the amount of time you spent on work or other activities	☐	☐	☐	☐	☐
b. Accomplished less than you would like	☐	☐	☐	☐	☐
c. Were limited in the kind of work or other activities	☐	☐	☐	☐	☐
d. Had difficulty performing the work or other activities (for example, it took extra effort)	☐	☐	☐	☐	☐

C5. During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
a. Cut down on the amount of time you spent on work or other activities	☐	☐	☐	☐	☐
b. Accomplished less than you would like	☐	☐	☐	☐	☐
c. Did work or activities less carefully than usual	☐	☐	☐	☐	☐

C6. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

☐ Not at all ☐ Quite a bit
☐ Slightly ☐ Extremely
☐ Moderately

C7. How much bodily pain have you had during the past 4 weeks?

☐ None ☐ Moderate
☐ Very mild ☐ Severe
☐ Mild ☐ Very severe

C8. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

☐ Not at all ☐ Quite a bit
☐ A little bit ☐ Extremely
☐ Moderately

Please! Do not mark below this line

C9. For pain that you have had during the past 4 weeks, where has this pain been located? *(Check all that apply)*

- ☐ Head
- ☐ Abdomen
- ☐ Neck
- ☐ Back
- ☐ Chest
- ☐ Pelvis
- ☐ Hands/Arms
- ☐ Legs/Feet
- ☐ Other

Specify

C10. These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please mark the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks. . .

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
a. Did you feel full of life?	☐	☐	☐	☐	☐
b. Have you been very nervous?	☐	☐	☐	☐	☐
c. Have you felt so down in the dumps that nothing could cheer you up?	☐	☐	☐	☐	☐
d. Have you felt calm and peaceful?.	☐	☐	☐	☐	☐
e. Did you have a lot of energy?	☐	☐	☐	☐	☐
f. Have you felt downhearted and depressed?	☐	☐	☐	☐	☐
g. Did you feel worn out?	☐	☐	☐	☐	☐
h. Have you been happy?	☐	☐	☐	☐	☐
i. Did you feel tired?	☐	☐	☐	☐	☐

C11. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?

- ☐ All of the time
- ☐ A little of the time
- ☐ Most of the time
- ☐ None of the time
- ☐ Some of the time

C12. How TRUE or FALSE is each of the following statements for you?

	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
a. I seem to get sick a little easier than other people	☐	☐	☐	☐	☐
b. I am as healthy as anybody I know	☐	☐	☐	☐	☐
c. I expect my health to get worse	☐	☐	☐	☐	☐
d. My health is excellent	☐	☐	☐	☐	☐

Sun Sensitivity

C13. How many days in the last 12 months have you used any artificial tanning devices such as a sun lamp, or gone to a tanning booth?

- ☐ None
- ☐ 1-5 days
- ☐ 6-10 days
- ☐ 11 or more days

C14. When you were outside last summer for more than 15 minutes, how often did you protect yourself from the sun by . . .

	Never	Rarely	Sometimes	Often	Always
Applying a sunscreen with a sun protection factor (SPF) of 15 or more on all sun exposed skin areas	☐	☐	☐	☐	☐
Wearing protective clothing such as long-sleeved shirts and long pants	☐	☐	☐	☐	☐
Wearing a hat	☐	☐	☐	☐	☐
Limiting exposure to the sun during the mid-day hours	☐	☐	☐	☐	☐
Staying in the shade	☐	☐	☐	☐	☐

Please! Do not mark below this line

C15. Since your last visit, have you been told that you had skin cancer? This includes basal cell, squamous cell, and melanoma.

☐ No → *Go to Question C16.*

☐ Yes

What was the name of the disease?

Where was the skin cancer located on your body? (Example: upper right arm, left ear)

When was this diagnosed?

Month (mm) Year (yyyy)

If you don't remember the date when the skin cancer was diagnosed, please give your approximate age at the time, or a time period when it happened (*for example*, between 1980 and 1983).

Where was this diagnosed?

Doctor's name

Hospital or clinic

Address

City, State, Zipcode

If you had more than one occurrence of skin cancer, please use a separate sheet of paper.

Smoking

C16. Do you smoke cigarettes now?

☐ No

☐ Yes

C17. On average, how many cigarettes a day do/did you smoke?

C18. How many years, in total, have you smoked?

C19. If you currently smoke, how many times in the past 12 months have you tried to quit smoking and not smoked for at least 24 hours?

C20. In the past year, have you ever used any of these tobacco products? *(Mark all that apply)*

	Never used	No longer use	Occasionally use	Regularly use
Chewing tobacco	☐	☐	☐	☐
Snuff tobacco	☐	☐	☐	☐
Pipes	☐	☐	☐	☐
Cigars	☐	☐	☐	☐

C21. For any of those that you have used or are currently using, how long have you used it?

	Less than 1 year	1 - 2 years	3 - 4 years	5 - 10 years	11+ years
Chewing tobacco	☐	☐	☐	☐	☐
Snuff tobacco	☐	☐	☐	☐	☐
Pipes	☐	☐	☐	☐	☐
Cigars	☐	☐	☐	☐	☐

Please! Do not mark below this line

C22. If you are no longer using the listed tobacco products, how long have you been quit?

☐☐

Drug Use

C23. Since your last SJLIFE visit, how many times have you tried…

C24. During the past 30 days, how many times did you use…

	Never	1 - 2 times	3 - 9 times	10 - 19 times	20 - 39 times	40 - 99 times	100 or more times
Marijuana/Hashish/Cannabis .	☐	☐	☐	☐	☐	☐	☐
Cocaine/Crack/Freebase	☐	☐	☐	☐	☐	☐	☐
Methamphetamine/Speed/ Ice/Crystal Meth/Ecstasy	☐	☐	☐	☐	☐	☐	☐

	Never	1 - 2 times	3 - 9 times	10 - 19 times	20 - 39 times	40 - 99 times	100 or more times
Marijuana/Hashish/Cannabis .	☐	☐	☐	☐	☐	☐	
Cocaine/Crack/Freebase	☐	☐	☐	☐	☐	☐	
Methamphetamine/Speed/ Ice/Crystal Meth/Ecstasy	☐	☐	☐	☐	☐	☐	

Alcohol

C25. During the last 12 months, what is the largest number of drinks you had on any single day? Was it. . .

- ☐ 24+ drinks
- ☐ 12-23 drinks
- ☐ 8-11 drinks
- ☐ 5-7 drinks
- ☐ 4 drinks
- ☐ 3 drinks
- ☐ 2 drinks
- ☐ 1 drink
- ☐ 0 drinks → *Go to Question C27, next page.*

C26. During the last 12 months, how often did you usually have any kind of drink containing alcohol?

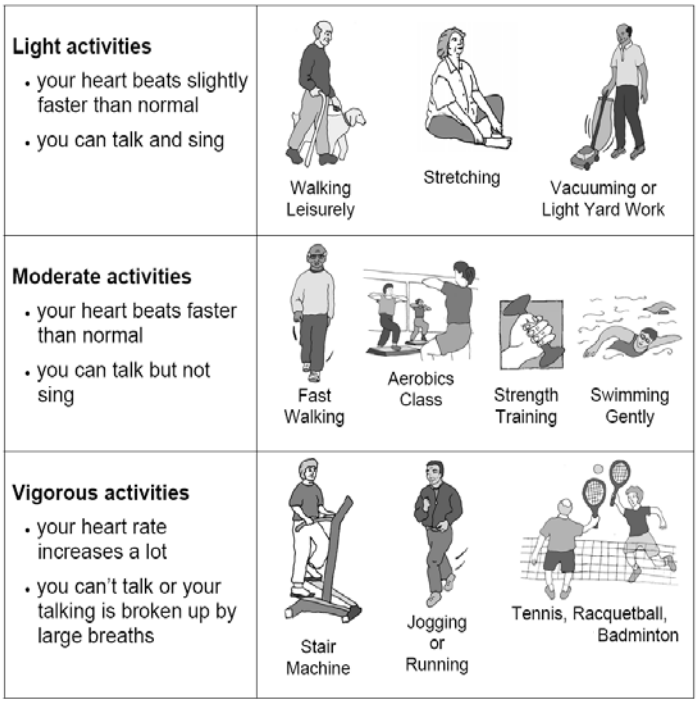
- ☐ Every day
- ☐ 5 to 6 times a week
- ☐ 3 to 4 times a week
- ☐ twice a week
- ☐ once a week
- ☐ 2 to 3 times a month
- ☐ once a month
- ☐ 3 to 11 times in the past year
- ☐ 1 or 2 times in the past year
- ☐ Never in the past year

Please! Do not mark below this line

For questions C27 through C29b, refer to the activity graphic below.

Physical Activity

Examples of physical activity intensity levels:



C27. On how many of the <u>past 7 days</u> did you exercise or do sports for at least 20 minutes that made you sweat or breathe hard (e.g., dancing, jogging, basketball, etc.)?

- ☐ 0 days
- ☐ 1 day
- ☐ 2 days
- ☐ 3 days
- ☐ 4 days
- ☐ 5 days
- ☐ 6 days
- ☐ 7 days

C28. Now thinking about the <u>vigorous physical activities</u> you do in a usual week, do you do vigorous activities for at least 10 minutes at a time, such as running, aerobics, wheelchair basketball, heavy yard work, or anything else that causes large increases in breathing or heart rate?

☐ No → *Go to Question C29.*

☐ Yes

C28a. How many days per week do you do these <u>vigorous activities</u> for at least 10 minutes at a time?

☐ **days per week**

C28b. On days when you do <u>vigorous activities</u> for at least 10 minutes at a time, how much total time per day do you spend doing these activities?

☐☐☐ **minutes per day**

C29. Now thinking about <u>moderate physical activities</u> you do in a usual week, do you do moderate activities for at least 10 minutes at a time, such as brisk walking, bicycling, gardening, manual operation of a wheelchair, or anything else that causes small increases in breathing or heart rate?

☐ No → *Go to Question D1.*

☐ Yes

C29a. How many days per week do you do these <u>moderate activities</u> for at least 10 minutes at a time?

☐ **days per week**

C29b. On days when you do <u>moderate activities</u> for at least 10 minutes at a time, how much total time per day do you spend doing these activities?

☐☐☐ **minutes per day**

Please! Do not mark below this line

Questions D1 to D18 relate to the past 7 days.

Below is a list of problems people sometimes have. Please read each one carefully and mark the box that best describes how much that problem has distressed or bothered you during the past 7 days including today. ***Mark only one answer for each problem and try not to skip any items. If you change your mind, erase the first mark carefully.***

	Not at all	A little bit	Moderately	Quite a bit	Extremely
D1. Nervousness or shaking inside.	☐	☐	☐	☐	☐
D2. Faintness or dizziness.	☐	☐	☐	☐	☐
D3. Pains in heart or chest.	☐	☐	☐	☐	☐
D4. Thoughts of ending your life	☐	☐	☐	☐	☐
D5. Suddenly scared for no reason.	☐	☐	☐	☐	☐
D6. Feeling lonely.	☐	☐	☐	☐	☐
D7. Feeling blue.	☐	☐	☐	☐	☐
D8. Feeling no interest in things	☐	☐	☐	☐	☐
D9. Feeling fearful	☐	☐	☐	☐	☐
D10. Nausea or upset stomach.	☐	☐	☐	☐	☐
D11. Trouble getting your breath.	☐	☐	☐	☐	☐
D12. Numbness or tingling in parts of your body.	☐	☐	☐	☐	☐
D13. Feeling hopeless about the future.	☐	☐	☐	☐	☐
D14. Feeling weak in parts of your body	☐	☐	☐	☐	☐
D15. Feeling tense or keyed up.	☐	☐	☐	☐	☐
D16. Spells of terror or panic.	☐	☐	☐	☐	☐
D17. Feeling so restless you couldn't sit still.	☐	☐	☐	☐	☐
D18. Feelings of worthlessness.	☐	☐	☐	☐	☐

Continue on next page.

MARITAL STATUS

E1. What is your current living arrangement?
(Mark all that apply)

- ☐ Live with spouse/partner
- ☐ Live with parent(s)
- ☐ Live with roommate(s)
- ☐ Live with brother(s) and/or sister(s)
- ☐ Live with other relative(s) (not including minor children)
- ☐ Live alone
- ☐ Other *Specify*

E2. Which of the following best describes your current marital status?

- ☐ Single, never married or never lived with partner as married
- ☐ Married
- ☐ Living with a partner as married
- ☐ Widowed
- ☐ Divorced
- ☐ Separated or no longer living as married

EMPLOYMENT HISTORY

F1. What is your current employment status? Include unpaid work in the family business or farm.
(Mark all that apply)

- ☐ Not currently working → *Go to Question G1.*
- ☐ Working full-time (30 or more hours per week)
- ☐ Working part-time (less than 30 hours per week)
- ☐ Caring for home or family (not seeking paid work)
- ☐ Unemployed and looking for work
- ☐ Unable to work due to illness or disability
- ☐ Retired
- ☐ Student
- ☐ Other *Specify.*

F2. The following questions are about your present occupation. Please write your job title and brief details of what you do. If you have more than one job, please give the title of your main job (please give only one):

F2a. Main job title:

F2b. Please briefly describe your primary job tasks:

Please! Do not mark below this line

INCOME

G1. Over the last year, what was the total income of the household you live in?

- ☐ Less than $19,999
- ☐ $20,000 - $39,999
- ☐ $40,000 - $59,999
- ☐ $60,000 - $79,999
- ☐ $80,000 - $99,999
- ☐ Over $100,000
- ☐ Don't know

G2. During the past year, how many people in this household were supported on this income?

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9 or more

G3. Over the last year, what was your personal income?

- ☐ None
- ☐ Less than $19,999
- ☐ $20,000 - $39,999
- ☐ $40,000 - $59,999
- ☐ $60,000 - $79,999
- ☐ $80,000 - $99,999
- ☐ Over $100,000

INSURANCE

H1. Do you currently have health insurance coverage?

- ☐ Canadian resident → *Go to back of survey.*
- ☐ No → *Go to back of survey.*
- ☐ Yes

H2. How is this insurance provided? *(Mark all that apply)*

- ☐ Through your place of employment
- ☐ Through your spouse's or parent's policy
- ☐ Through a policy you have purchased yourself
- ☐ Medicaid or other public assistance program
- ☐ Medicare
- ☐ Military dependant/Veteran's benefits (CHAMPUS)
- ☐ Other *Specify.*

H2a. Does this health insurance plan have any exclusions or restrictions because of your health history?

- ☐ Don't know
- ☐ No
- ☐ Yes *Specify.*

H2b. Is there an extra premium charge on your health insurance policy because of your health history?

- ☐ Don't know
- ☐ No
- ☐ Yes

Please! Do not mark below this line

For our future planning, what type of information or help do you think should be available to survivors of childhood cancer, leukemia, tumor, or similar illnesses?

Attach additional pages, if necessary.

We have your current address and phone as:

Is this information correct, or are you planning on moving in the next 6 months?

☐ Correct ☐ Not correct ☐ Moving

Do you have an email address we could use to contact you?

☐ No ☐ Yes

Your Email Address

Please give us your correct address or location (if different from above):

Address		
City	State	
Zip Code	Home Phone Number	Cell Phone Number

Please provide the name and address of someone who could give us your new address should you move. We will contact this person only if we are unable to reach you at your home address.

Name	
Address	Relationship to you
City	State
Zip Code	Phone Number

When you have completed this questionnaire please return it to us in the enclosed envelope.

Mail to:

SJLIFE STUDY
St. Jude Children's Research Hospital
Department of Epidemiology
Mail Stop 735
262 Danny Thomas Place
Memphis, TN 38105-3678

Thank you!

Please! Do not mark below this line