FERNALD MEDICAL MONITORING PROGRAM

Could you please answer several questions about your medical history?

1. Has a doctor ever told you that you have cancer?

   ☐ No  ☐ Yes  Mouth cancer?  If YES, Year of diagnosis _______

   ☐ No  ☐ Yes  Laryngeal (voice box) cancer?  If YES, Year of diagnosis _______

   ☐ No  ☐ Yes  Cancer of the esophagus?  If YES, Year of diagnosis _______

   ☐ No  ☐ Yes  Lung cancer?  If YES, Year of diagnosis _______

   ☐ No  ☐ Yes  Stomach cancer?  If YES, Year of diagnosis _______

   ☐ No  ☐ Yes  Colon/rectal cancer?  If YES, Year of diagnosis _______

   ☐ No  ☐ Yes  Gallbladder cancer?  If YES, Year of diagnosis _______

   ☐ No  ☐ Yes  Liver cancer?  If YES, Year of diagnosis _______

   ☐ No  ☐ Yes  Cancer of the pancreas?  If YES, Year of diagnosis _______

   ☐ No  ☐ Yes  Kidney cancer?  If YES, Year of diagnosis _______

   ☐ No  ☐ Yes  Bladder cancer?  If YES, Year of diagnosis _______

   ☐ No  ☐ Yes  Bone cancer?  If YES, Year of diagnosis _______

   ☐ No  ☐ Yes  Brain cancer?  If YES, Year of diagnosis _______

   ☐ No  ☐ Yes  Breast cancer?  If YES, Year of diagnosis _______

   ☐ No  ☐ Yes  Leukemia?  If YES, Year of diagnosis _______

   ☐ No  ☐ Yes  Hodgkin’s disease?  If YES, Year of diagnosis _______

   ☐ No  ☐ Yes  Malignant melanoma?  If YES, Year of diagnosis _______

   MALES ONLY:

   ☐ No  ☐ Yes  Prostate cancer?  If YES, Year of diagnosis _______

   ☐ No  ☐ Yes  Cancer of the Testicles?  If YES, Year of diagnosis _______

   FEMALES ONLY:
Cervical cancer?  If YES, Year of diagnosis ______

Cancer of the uterus?  If YES, Year of diagnosis ______

BOTH MALE AND FEMALE:

Other type of cancer?  If YES, Year of diagnosis ______

Type: __________________________________________

Has a doctor ever told you that you had any of the following medical conditions?

Goiter?  If YES, Year of diagnosis ______

Other type of thyroid disease?  If YES, Year of diagnosis ______

Asthma?  If YES, Year of diagnosis ______

Chronic Bronchitis  If YES, Year of diagnosis ______

Emphysema?  If YES, Year of diagnosis ______

Diabetes Mellitus?  If YES, Year of diagnosis ______

Hypertension (high blood pressure)?  If YES, Year of diagnosis ______

Nephritis?  If YES, Year of diagnosis ______

Kidney Stones?  If YES, Year of diagnosis ______

Repeated kidney infections?  If YES, Year of diagnosis ______

Other kidney problems?  If YES, Year of diagnosis ______

Bladder problems?  If YES, Year of diagnosis ______

Cataracts?  If YES, Year of diagnosis ______

Any other previous medical condition?

If YES, What? _________________________________ Year of diagnosis ______