In order to conduct more research studies, we are updating our records about cancer and other illness in participants of the Fernald Medical Monitoring Program (now the Fernald Community Cohort). Knowing that you do not have an illness (“No”) is just as important to us as knowing that you have an illness.

1. Has a doctor ever told you that you have cancer? We are asking about primary cancers, not cancers that have traveled from one place in your body to another place.

□ No  □ Yes  Mouth cancer?  If YES, Year of diagnosis _________
□ No  □ Yes  Larynx (voice box) cancer?  If YES, Year of diagnosis _________
□ No  □ Yes  Thyroid 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? (female or male)  If YES, Year of diagnosis _________
□ No  □ Yes  Leukemia?  If YES, Year of diagnosis _________
□ No  □ Yes  Hodgkin’s disease? (Lymphoma)  If YES, Year of diagnosis _________
□ No  □ Yes  Malignant melanoma?  If YES, Year of diagnosis _________
□ No  □ Yes  Other type of cancer?  If YES, Year of diagnosis _________

Type: __________________________________________________
MALES ONLY:

☐ No  ☐ Yes  Prostate cancer?  If YES, Year of diagnosis _________
☐ No  ☐ Yes  Cancer of the Testicles?  If YES, Year of diagnosis _________

FEMALES ONLY:

☐ No  ☐ Yes  Cervical cancer?  If YES, Year of diagnosis _________
☐ No  ☐ Yes  Cancer of the uterus?  If YES, Year of diagnosis _________

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

☐ No  ☐ Yes  Goiter/thyroid condition?  If YES, Year of diagnosis _________
☐ No  ☐ Yes  Asthma?  If YES, Year of diagnosis _________
☐ No  ☐ Yes  Chronic Bronchitis?  If YES, Year of diagnosis _________
☐ No  ☐ Yes  Emphysema?  If YES, Year of diagnosis _________
☐ No  ☐ Yes  Diabetes Mellitus?  If YES, Year of diagnosis _________

Do you take insulin?  ____ NO  ____ YES

☐ No  ☐ Yes  Hypertension (high blood pressure)?  If YES, Year of diagnosis _________
☐ No  ☐ Yes  Kidney disease?  If YES, Year of diagnosis _________

Have you been on dialysis?  ____ NO  ____ YES
☐ No  ☐ Yes  Kidney Stones?  If YES, Year of diagnosis _________
☐ No  ☐ Yes  Lupus?  If YES, Year of diagnosis _________
☐ No  ☐ Yes  Fibromyalgia (chronic fatigue)  If YES, Year of diagnosis _________
☐ No  ☐ Yes  Cataracts?  If YES, Year of diagnosis _________
☐ No  ☐ Yes  Any other previous medical condition?

If YES, What?  ______________________________ Year of diagnosis _________

What is your email address?  (Please print)  ___________________________@_______________________

Phone number:  (____ ___ ___) - ___ ___ ___ - ___ ___ ___ ___

Has your last name changed?  ____ Yes  ____ No  If YES, new last name:  ________________________________

THANK YOU FOR UPDATING YOUR INFORMATION WITH THE FERNALD COMMUNITY COHORT

Please return this form in the enclosed postage prepaid envelope.
If you do not have the postage prepaid envelope, please mail to: Jeanette Buckholz, UC FCC, PO Box 670056, Cincinnati, OH, 45267-0056