

LIFE Study Questionnaire

Follow-up

L	I	F							BRONCH#			0	0							
									REC	0	1			SUB	0	0			BLANK	
									FORM	0	2			VER	0	1				
									START TIME:			:			AM		PM			
									FINISH TIME:			:			AM		PM			
									INTERVIEW LENGTH:					minutes						
									Interviewer:											

Thank you for agreeing to answer these follow-up questions. These questions will cover your smoking habits, medical history and dietary habits since your previous study bronchoscopy.

Everything you tell me in the interview will be kept private and confidential, as is required by law. Your name does not go on this form, only an ID number does. But, if for any reason you would rather not answer a question, we can skip it and go to the next.

Do you have any questions before we begin?

Today's date:

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 /

--	--	--

 /

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(month) *(day)* *(year)*

Date of birth: _____

Age now: _____

Specify Previous Branch:

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 /

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(month) *(year)*

Current Branch:

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 /

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(month) *(year)*

KEEP THIS FLAP OPEN DURING THE INTERVIEW

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Section A: Smoking History

First I have some questions about cigarettes and other tobacco products. I would like you to think about your smoking and/or other tobacco use since the last study bronchoscopy done on [INSERT PREVIOUS DATE].

[IF YES:]			
A1. Since [TIME PERIOD], did you smoke cigarettes at all?	A2. During that time period, did you smoke the whole time or part of that time?	A3. On average since [TIME PERIOD], how many cigarettes did you smoke per day, week or month?	A4. During that time, did you inhale?
YES 1 NO[A8].....2 DK[A8].....8	WHOLE..... 1 PART 2	<div style="text-align: center;">  <p># PER</p> DAY..... 1 WEEK..... 2 MONTH..... 3 IN TOTAL 4 </div>	YES 1 NO 2

[IF YES:]		[IF YES:]	
A8. Since [TIME PERIOD], did you smoke a pipe? (on a regular basis i.e: at least once a day for 6 months?)	A8a. During that time, on average, how many pipefuls did you smoke per day, week or month?	A9. Since [TIME PERIOD], did you smoke a cigar? (on a regular basis i.e: at least once a day for 6 months?)	A9a. During that time, on average, how many cigars did you smoke per day, week or month?
YES 1 NO[A9]..... 2	<div style="text-align: center;">  <p># PER</p> DAY 1 WEEK 2 MONTH 3 IN TOTAL 4 </div>	YES..... 1 NO [A10]2	<div style="text-align: center;">  <p># PER</p> DAY 1 WEEK 2 MONTH 3 IN TOTAL 4 </div>

[IF YES TO A1, ASK:]		
A5. Did you smoke filtered or unfiltered cigarettes?	A6. What brand of cigarettes did you smoke the most during that time?	A7. When did you last smoke a cigarette? Please tell me the date and time.
FILTERED 1 UNFILTERED.....2 BOTH3	[BRAND] <input type="text"/> [TYPE OR OTHER DESCRIPTION FOR BRAND] <input type="text"/>	DATE: <input type="text"/> / <input type="text"/> / <input type="text"/> <i>(month) (day) (year)</i> AND TIME: <input type="text"/> : <input type="text"/> am <input type="checkbox"/> <i>(hrs) (mins) pm</i>

	[IF YES:]		[IF YES:]
A10. Since [TIME PERIOD], did you use chewing tobacco on a regular basis? (i.e: at least once a day for at least 6 months?)	A10a. During that time, on average, how many hours per day did you have chewing tobacco in your mouth?	A11. Since [TIME PERIOD], did you use snuff on a regular basis? (i.e: at least once a day for at least 6 months?)	A11a. During that time, on average, how many hours per day did you have snuff in your mouth?
YES..... 1 NO.....[A11].....2	<input type="text"/> #HOURS	YES 1 NO[B1].....2	<input type="text"/> #HOURS

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Section B: Dietary

B1. Since [TIME PERIOD], have you taken any vitamins or supplements?

Yes, fairly regularly.....1
 Yes, but not regularly2
 No[B5]3

[IF YES:]

	B2. Did you take...	B3. How often did you take [VITAMIN]?							B4. Since [TIME PERIOD], how long have you been taking [VITAMIN]?	
	None (01)	1-3 per wk (02)	4-6 per wk (03)	1 per day (04)	2 per day (05)	3 per day (06)	4 per day (07)	5+ per day (08)		
□ □	a. One-a-day type								□ □ # MONTHS	
□ □	b. Stress-tabs type								□ □ # MONTHS	
□ □	c. Therapeutic, Theragran type								□ □ # MONTHS	
	Other Vitamins	None (01)	1-3 per wk (02)	4-6 per wk (03)	1 per day (04)	2 per day (05)	3 per day (06)	4 per day (07)	5+ per day (08)	
□ □	d. Vitamin A								□ □ # MONTHS	
□ □	e. Vitamin C								□ □ # MONTHS	
□ □	f. Vitamin E								□ □ # MONTHS	
□ □	g. BetaCarotene								□ □ # MONTHS	
	Other Vitamins	None (01)	1-3 per wk (02)	4-6 per wk (03)	1 per day (04)	2 per day (05)	3 per day (06)	4 per day (07)	5+ per day (08)	
□ □	h. Other #1								□ □ # MONTHS	
□ □ □ □	[IF YES:] Specify: _____									
□ □	i. Other #2								□ □ # MONTHS	
□ □ □ □	[IF YES:] Specify: _____									

B5.		Never or <1 per mo (01)	1 per mo (02)	2-3 per mo (03)	1 per wk (04)	2 per wk (05)	3-4 per wk (06)	5-6 per wk (07)	Daily (08)
<input type="checkbox"/>	a. leafy greens (lettuce, cabbage, collards, spinach, etc.)?								
<input type="checkbox"/>	b. vegetables (beans, corn, peas, potatoes, etc.)?								
<input type="checkbox"/>	c. fruits or fruit juices?								
<input type="checkbox"/>	d. cold cereals? [IF YES:] Which cereal did you eat mostly?								
<input type="checkbox"/>	_____								

Section C: Alcohol and Coffee Consumption

Now I am going to ask you about alcoholic beverages and coffee consumption. One alcoholic drink is defined as a 12 ounce glass of beer, 4 ounces of wine or a shot of hard liquor.

C1. Since [TIME PERIOD], how many alcoholic drinks did you have per day, (week or month)?	C2. Since [TIME PERIOD], how many cups of coffee did you have per day, (week or month)?	C3. How many of those [# CUPS] were caffeinated or decaffeinated coffee?
<div style="display: flex; justify-content: center; gap: 10px;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <p># DRINKS PER</p> <p>DAY 1</p> <p>WEEK 2</p> <p>MONTH 3</p> <p>IN TOTAL 4</p>	<div style="display: flex; justify-content: center; gap: 10px;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <p># CUPS</p> <p>[IF NONE, CODE "000" AND GO TO D1]</p> <p>DAY 1</p> <p>WEEK 2</p> <p>MONTH 3</p> <p>IN TOTAL 4</p>	<div style="display: flex; justify-content: center; gap: 10px;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <p>#CUPS CAF</p> <p>AND</p> <div style="display: flex; justify-content: center; gap: 10px;"> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> <div style="border: 1px solid black; width: 20px; height: 20px;"></div> </div> <p>#CUPS DECAF</p>

Section D: Medical History

Now, I would like to ask you about your medical history. Again, if you cannot recall exact answers, please give me your best recollection.

				[IF YES OR NOT SURE, ASK D2 - D4.]					
D1.				D2.		D3.		D4.	
Since [TIME PERIOD], have you been diagnosed for the first time with [CONDITION]?				What month and year were you diagnosed since [TIME PERIOD]?		Were you hospitalized?		Were you given medication or other treatment for this condition? (A treatment might be a special diet or changes in lifestyle.)	
CONDITION	YES	NOT SURE	NO	MONTH	YEAR	Y	N	Y	N
a. heart disease or a heart attack	1	3	2	_ _	_ _ _ _	1	2	1	2
b. congestive heart failure (or fluid in your lungs)	1	3	2	_ _	_ _ _ _	1	2	1	2
c. high blood pressure	1	3	2	_ _	_ _ _ _	1	2	1	2
d. diabetes	1	3	2	_ _	_ _ _ _	1	2	1	2
e. pneumonia	1	3	2	_ _	_ _ _ _	1	2	1	2
f. asthma	1	3	2	_ _	_ _ _ _	1	2	1	2
g. emphysema	1	3	2	_ _	_ _ _ _	1	2	1	2
h. chronic bronchitis	1	3	2	_ _	_ _ _ _	1	2	1	2
i. a blood clot in your lung (pulmonary embolism)	1	3	2	_ _	_ _ _ _	1	2	1	2
j. a tumor that was not cancer (benign tumor)	1	3	2	_ _	_ _ _ _	1	2	1	2
k. cancer of the pleura (mesothelioma)	1	3	2	_ _	_ _ _ _	1	2	1	2
l. lung cancer	1	3	2	_ _	_ _ _ _	1	2	1	2
m. any other kind of cancer [IF YES, SPECIFY:]	1	3	2						
1. _____			_ _	_ _	_ _ _ _	1	2	1	2
2. _____			_ _	_ _	_ _ _ _	1	2	1	2

[IF YES OR NOT SURE, ASK D2 - D4.]

D1. Since [TIME PERIOD], have you been diagnosed for the first time with [CONDITION]?				D2. What month and year were you diagnosed since [TIME PERIOD]		D3. Were you hospitalized?		D4. Were you given medication or other treatment for this condition? (A treatment might be a special diet or changes in lifestyle.)	
CONDITION	YES	NOT SURE	NO	MONTH	YEAR	Y	N	Y	N
n. sarcoidosis	1	3	2	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	1	2	1	2
o. tuberculosis	1	3	2	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	1	2	1	2
p. non-tubercular mycobacterial infection (a cousin of tuberculosis)	1	3	2	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	1	2	1	2
q. a fungal infection of the lung (for example, aspergillus)	1	3	2	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	1	2	1	2
r. pulmonary fibrosis (interstitial lung disease, scarring of the lungs)	1	3	2	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	1	2	1	2
s. systemic lupus erythematosus (SLE)	1	3	2	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	1	2	1	2
t. Wegener's disease	1	3	2	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	1	2	1	2
u. lung abscess	1	3	2	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	1	2	1	2
v. a collapsed lung (or pneumothorax)	1	3	2	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	1	2	1	2
w. gunshot to the lung or any other lung trauma	1	3	2	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	1	2	1	2
x. any other health condition that has been a serious problem for you [IF YES, SPECIFY:]	1	3	2						
1. _____		<input type="text"/> <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	1	2	1	2
2. _____		<input type="text"/> <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	1	2	1	2
3. _____		<input type="text"/> <input type="text"/> <input type="text"/>		<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	1	2	1	2

D5. Have you had lung surgery since [TIME PERIOD]?
 YES1
 NO2
 DON'T KNOW8

D6. Since [TIME PERIOD], have you had radiation therapy?
 YES1
 NO[D8].....2
 DON'T KNOW[D8].....8

[IF YES:]

D7. What part of your body was radiated?
 a. _____
 b. _____
 c. _____

D8. Since [TIME PERIOD], have you had chemotherapy?
 YES1
 NO[D10].....2
 DON'T KNOW[D10].....8

[IF YES:]

D9. For what condition did you receive chemotherapy?
 a. _____
 b. _____
 c. _____

D10. Since [TIME PERIOD], have you had a cough productive of sputum most mornings?
 YES1
 NO [SECTION E]2
 DON'T KNOW ... [SECTION E]8

[IF YES:]

D11. During how many months (did/have) you (have/had) this cough?

 # MONTHS
 (<1 MONTH = 00)

Section E: Closing

- E1. Considering the kinds of questions we've asked in this interview, is there anything else you think we need to know?

These are all the questions I have for you. Thank you very much for your patience and cooperation.

Please understand that the questions I've asked you about different lifestyle habits are standard questions in this type of research study. It is not known whether any of these things can cause any particular medical problems.

Section F: Interviewer Remarks

- F1. Was the subject helped by a proxy? YES1
 NO[F4].....2

[IF YES:]

F2. Proxy's relationship to subject:

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F3. To what extent did the proxy contribute information?

- Low.....1
 Medium2
 High3

F4. The overall quality of responses was:

- High quality[F7].....1
 Generally reliable[F7].....2
 Questionable[F5].....3
 Unsatisfactory.....[F5].....4
 Other.....5

SPECIFY:

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[IF F4 IS ANSWERED 3, 4, OR 5 ABOVE:]

F5. The main reason for questionable or unsatisfactory quality of information was because the respondent:

- Did not know enough information regarding the topic01
 Did not want to be more specific02
 Sounded bored or uninterested.....03
 Sounded upset, depressed or angry04
 Had poor hearing or speech.....05
 Was confused or distracted by frequent interruptions.....06
 Was inhibited by others around him or her07
 Was embarrassed by the subject matter08
 Was emotionally unstable09
 Was physically ill10
 Other.....11

SPECIFY:

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F6.	The respondent had trouble with the following sections:	Y	N	DK
	A. Smoking History.....	1	2	8
	B. Dietary	1	2	8
	C. Alcohol and Coffee Consumption	1	2	8
	D. Medical History	1	2	8

F7. Use this space for any other comments you have which may affect the interpretation of this respondent's answers.
