

Health/Cancer Survey Questionnaire

Someone will collect your completed survey within the next few days; or, return it to the contact mentioned at the end of the survey. Participation and personal identification is completely voluntary. Personal information will be held in strict confidentiality, and not released to third parties without your written consent.

Section A – the affected area

Do you (circle all): live work near a nuclear site (e.g., waste storage/treatment site, nuclear reactor)? Yes No

If “yes,” name of facility: _____

Distance (e.g., in yards, miles) and direction (N,S,E,W, etc.) of your home/work from [the site above] _____

Do you live near (within 1km of) the sea/ a major lake with wave and tidal action (circle)? Yes No

How many boys and men live at your address? Number: _____ Ages: _____

How many girls and women live at your address? Number: _____ Ages: _____

Section B – medical background information

Part 1.: general medical information

Has anyone in your household been diagnosed with any cancer/leukemia/lymphoma in the last 5 years? Yes No

If “yes,” please provide the following information:

	Person 1	Person2	Person 3	Person 4
Gender				
Year and Age at Diagnosis				
Type of cancer/leukemia/lymphoma diagnosed				
How long has person lived in this area?				
Where did they live before? How long?				
Did/does this person receive treatment/surgery?				
Name of doctor/treating facility				
If this person experienced any other serious health condition, please state what, date of , and age at diagnosis:				
Treatment, and doctor/treating facility for these “other” conditions:				
If the person smokes(ed) more than 10 cigarettes/day before the diagnosis, state dates and #				
Is this person still alive?				

Part 2.: birth/children (neonatal/pediatric) history

Sub-Part a.: neonatal/infancy information	Person 1	Person 2	Person 3
Has any female living in your household experienced (circle all that apply; if “yes” to infant death, add how long after birth):	Still birth Miscarriage Birth defect(s) Infant death	Still birth Miscarriage Birth defect(s) Infant death	Still birth Miscarriage Birth defect(s) Infant death
If so, in what year did this/these occur?			
How long had the mother lived in the affected area?			

Where had the mother lived before?			
Mother's occupation, if any, with dates:			
If the mother smokes(-ed) more than 10 cigarettes/day prior to having the baby, state dates and # smoked/day			
Sub-Part b. – childhood information: If any children in your household currently experience/have experienced any cancer/leukemia/lymphoma while living, schooling, playing, or working in the area in Section A above, please provide the following information:			
Gender/current age			
Diagnosis of condition; age and year of onset			
Treatment received/receiving:			
Treating physician/facility; contact number			

Section C

Please answer these questions if you said "Yes" to any of the questions in sections B:

Are any of these people regularly in or close to the facility in Section A for work, school or pleasure? Yes No

Please describe/state how often: _____

Is this activity mostly (circle): indoors outdoors evenly split

If this activity is outdoors, are they regularly in or in close contact with the site in Section A above? Yes No

Describe/state how often: _____

Would you be prepared to help by answering further questions if necessary? Yes No

Would you like a copy of the results of the survey when available? Yes No

If "Yes" to either of the previous two questions, please leave your name, address, telephone, and e-mail contact below.

Please add anything you feel relevant to the information on the questionnaire:

Name: _____

Contact Address: _____ State: _____ Zip: _____

Contact phone: _____

Contact e-mail: _____

Thank you for your time! If you have any further questions, please contact:

CODE:

Please return all completed questionnaires to: