Jefferson Pancreas Tumor Registry Questionnaire
(completed by NON-AFFECTED Family Member)

Please fill in the information requested. If you do not know how to answer a question, please leave it blank. We will contact you to complete any unanswered questions.

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1. Last Name: _____ First Name: _____ MI: _____

   Name of Affected Family Member: _____

2. Today's Date: ____/____/____
   Mo Day Year

3. a. Your ethnic group:

   a. ☐ Caucasian
   b. ☐ Hispanic
   c. ☐ African-American
   d. ☐ Asian-American
   e. ☐ Native American
   f. ☐ Other _____

Please indicate Registry Site where you enrolled:

- ☐ Thomas Jefferson University Hospital
- ☐ Lankanau Hospital
- ☐ Bryn Mawr Hospital
- ☐ Paoli Hospital
- ☐ Riddle Hospital
- ☐ Poconos Medical Center
- ☐ Abington Health
- ☐ Internet
- ☐ Other _____

b. Was your mother Jewish? ___Yes ___No

If yes, is she of Ashkenazi (Eastern European/Russian background)? ___Yes ___No

c. Was your father Jewish? ___Yes ___No

If yes, is he of Ashkenazi (Eastern European/Russian background)? ___Yes ___No

4. Your date of birth: ____/____/____
   Mo Day Yr

5. Your gender: ☐ male ☐ female

6. Home address _____
   street

   _____
   city state zip code

   Email address: _____

   Daytime phone number (___)_____

   Evening phone number (___)_____

Thomas Jefferson University IRB
Approval Date 10/20/16
Approved until END OF STUDY

7. Contact person if you are unavailable:

_____
name

_____
street address

_____
city state zip

__(___)_____
telephone

8. Name, address, and phone number of your primary doctor:

_____
name

_____
street address

_____
city state zip

__(___)_____
telephone

9. Which of the following conditions have you been diagnosed with: (Check all that apply)

☐ Pancreas Cancer ☐ Bile Duct Cancer ☐ Duodenal Cancer ☐ Ampullary Cancer
☐ Pancreatitis ☐ IPMN ☐ Pancreas Cyst ☐ Other _____

How old were you when your pancreas tumor or other condition was diagnosed? _____

Date of diagnosis: _____

Were you treated with? ☐ Radiation Therapy ☐ Chemotherapy ☐ Surgery ☐ No Treatment

Name of the hospital where your pancreas or other tumor was diagnosed: _____

Have you had any other cancers or tumors? ☐ Yes ☐ No

Please describe: _____

_____

_____

_____

10. What is your height? _____feet _____inches

11. At present, how often do you smoke cigarettes? ☐ Never ☐ Occasionally ☐ Regularly

12. If you currently smoke or if you have ever smoked cigarettes, where the cigarettes:

☐ With filters ☐ Without filters ☐ Both with and without filters

a. How many cigarettes do (did) you usually smoke each day? _____

b. How old were you when you first started smoking cigarettes regularly? _____ years old

13. If you do not smoke cigarettes now, how old were you when you stopped smoking? _____ years old

On the average of the entire time you smoked, how many cigarettes did you smoke per day? _____

		Never	Occasionally	Regularly	
14.	Do (did) you smoke pipes or cigars?	____	____	____	How long? _____ years
15.	Do (did) you use chewing tobacco or snuff?	____	____	____	How long? _____ years

16. Have you **regularly spent 1 hour or more per day** in a room (at home or work) where someone other than you was smoking? Please check the appropriate box(es).

Between the ages:	**NO**	**YES**		
		Parent	**Significant Other**	**Co-worker**
0 - 20 years old?				
21 - 40 years old?				
41 - 60 years old?				
When older than 60 years?				

17. Please fill in the table. **FAMILY HISTORY**

FULL NAME	DATE OF BIRTH Mo/Day/Yr	ANY PANCREAS PROBLEMS?	ANY OTHER CANCERS, INHERITED ANEMIAS OR DISORDERS?	*SMOKER?	DECEASED?
Your mother's Name:		**Pancreas Cancer:** ☐ Yes ☐ No ☐Unknown **Diabetes:** ☐ Yes ☐ No ☐Unknown **Pancreatitis**: ☐ Yes ☐ No ☐Unknown Age(s) at Diagnosis:	☐ Yes ☐ No ☐ Unknown Type: Age at Diagnosis:	☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:
Your father's Name:		**Pancreas Cancer:** ☐ Yes ☐ No ☐Unknown **Diabetes:** ☐ Yes ☐ No ☐Unknown **Pancreatitis**: ☐ Yes ☐ No ☐Unknown Age(s) at Diagnosis:	☐ Yes ☐ No ☐ Unknown Type: Age at Diagnosis:	☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:
Your mother's mother's Name:		**Pancreas Cancer:** ☐ Yes ☐ No ☐Unknown **Diabetes:** ☐ Yes ☐ No ☐Unknown **Pancreatitis**: ☐ Yes ☐ No ☐Unknown Age(s) at Diagnosis:	☐ Yes ☐ No ☐ Unknown Type: Age at Diagnosis:	☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:
Your mother's father's Name:		**Pancreas Cancer:** ☐ Yes ☐ No ☐Unknown **Diabetes:** ☐ Yes ☐ No ☐Unknown **Pancreatitis**: ☐ Yes ☐ No ☐Unknown Age(s) at Diagnosis:	☐ Yes ☐ No ☐ Unknown Type: Age at Diagnosis:	☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:
Your father's mother's Name:		**Pancreas Cancer:** ☐ Yes ☐ No ☐Unknown **Diabetes:** ☐ Yes ☐ No ☐Unknown **Pancreatitis**: ☐ Yes ☐ No ☐Unknown Age(s) at Diagnosis:	☐ Yes ☐ No ☐ Unknown Type: Age at Diagnosis:	☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:
Your father's father's Name:		**Pancreas Cancer:** ☐ Yes ☐ No ☐Unknown **Diabetes:** ☐ Yes ☐ No ☐Unknown **Pancreatitis**: ☐ Yes ☐ No ☐Unknown Age(s) at Diagnosis:	☐ Yes ☐ No ☐ Unknown Type: Age at Diagnosis:	☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:
Your spouse's Name:		**Pancreas Cancer:** ☐ Yes ☐ No ☐Unknown **Diabetes:** ☐ Yes ☐ No ☐Unknown **Pancreatitis**: ☐ Yes ☐ No ☐Unknown Age(s) at Diagnosis:	☐ Yes ☐ No ☐ Unknown Type: Age at Diagnosis:	☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:

*Smoker = >100 cigarettes in Lifetime **Use the back of the form if necessary to explain any illnesses**.

18. How many brothers do you have? _______ How many sisters do you have? _______
If any of your brothers and sisters have different parents, please indicate which are half-siblings and whether blood relationship is through your mother or your father.

YOUR BROTHERS AND SISTERS

FULL NAME	**GENDER (F/M)**	**DATE OF BIRTH** Mo/Day/Yr	**ANY PANCREAS PROBLEMS?**	**ANY OTHER CANCERS, INHERITED ANEMIAS OR DISORDERS?**	***SMOKER?**	**DECEASED?**
			Pancreas Cancer: ☐ Yes ☐ No ☐Unknown **Diabetes:** ☐ Yes ☐ No ☐Unknown **Pancreatitis**: ☐ Yes ☐ No ☐Unknown Age(s) at Diagnosis:	☐ Yes ☐ No ☐ Unknown Type: Age at Diagnosis:	☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:
			Pancreas Cancer: ☐ Yes ☐ No ☐Unknown **Diabetes:** ☐ Yes ☐ No ☐Unknown **Pancreatitis**: ☐ Yes ☐ No ☐Unknown Age(s) at Diagnosis:	☐ Yes ☐ No ☐ Unknown Type: Age at Diagnosis:	☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:
			Pancreas Cancer: ☐ Yes ☐ No ☐Unknown **Diabetes:** ☐ Yes ☐ No ☐Unknown **Pancreatitis**: ☐ Yes ☐ No ☐Unknown Age(s) at Diagnosis:	☐ Yes ☐ No ☐ Unknown Type: Age at Diagnosis:	☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:
			Pancreas Cancer: ☐ Yes ☐ No ☐Unknown **Diabetes:** ☐ Yes ☐ No ☐Unknown **Pancreatitis**: ☐ Yes ☐ No ☐Unknown Age(s) at Diagnosis:	☐ Yes ☐ No ☐ Unknown Type: Age at Diagnosis:	☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:
			Pancreas Cancer: ☐ Yes ☐ No ☐Unknown **Diabetes:** ☐ Yes ☐ No ☐Unknown **Pancreatitis**: ☐ Yes ☐ No ☐Unknown Age(s) at Diagnosis:	☐ Yes ☐ No ☐ Unknown Type: Age at Diagnosis:	☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:

*Smoker = >100 cigarettes in Lifetime

Use back of form if necessary to explain any illnesses.

19. How many sons do you have? _______ How many daughters do you have? _______
Please complete the following for your children. Please indicate which of your children are half-siblings (have different mother or father).

YOUR CHILDREN

FULL NAME	GENDER (F/M)	DATE OF BIRTH Mo/Day/Yr	ANY PANCREAS PROBLEMS?	ANY OTHER CANCERS, INHERITED ANEMIAS OR DISORDERS?	*SMOKER?	DECEASED?
			Pancreas Cancer: ☐ Yes ☐ No ☐Unknown **Diabetes:** ☐ Yes ☐ No ☐Unknown **Pancreatitis**: ☐ Yes ☐ No ☐Unknown Age(s) at Diagnosis:	☐ Yes ☐ No ☐ Unknown Type: Age at Diagnosis:	☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:
			Pancreas Cancer: ☐ Yes ☐ No ☐Unknown **Diabetes:** ☐ Yes ☐ No ☐Unknown **Pancreatitis**: ☐ Yes ☐ No ☐Unknown Age(s) at Diagnosis:	☐ Yes ☐ No ☐ Unknown Type: Age at Diagnosis:	☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:
			Pancreas Cancer: ☐ Yes ☐ No ☐Unknown **Diabetes:** ☐ Yes ☐ No ☐Unknown **Pancreatitis**: ☐ Yes ☐ No ☐Unknown Age(s) at Diagnosis:	☐ Yes ☐ No ☐ Unknown Type: Age at Diagnosis:	☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:
			Pancreas Cancer: ☐ Yes ☐ No ☐Unknown **Diabetes:** ☐ Yes ☐ No ☐Unknown **Pancreatitis**: ☐ Yes ☐ No ☐Unknown Age(s) at Diagnosis:	☐ Yes ☐ No ☐ Unknown Type: Age at Diagnosis:	☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:
			Pancreas Cancer: ☐ Yes ☐ No ☐Unknown **Diabetes:** ☐ Yes ☐ No ☐Unknown **Pancreatitis**: ☐ Yes ☐ No ☐Unknown Age(s) at Diagnosis:	☐ Yes ☐ No ☐ Unknown Type: Age at Diagnosis:	☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:
			Pancreas Cancer: ☐ Yes ☐ No ☐Unknown **Diabetes:** ☐ Yes ☐ No ☐Unknown **Pancreatitis**: ☐ Yes ☐ No ☐Unknown Age(s) at Diagnosis:	☐ Yes ☐ No ☐ Unknown Type: Age at Diagnosis:	☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:

*Smoker = >100 cigarettes in Lifetime

20. Please fill in the table.

YOUR *MOTHER'S* SIBLINGS

FULL NAME	GENDER (F/M)	DATE OF BIRTH Mo/Day/Yr	ANY PANCREAS PROBLEMS?	ANY OTHER CANCERS, INHERITED ANEMIAS OR DISORDERS?	*SMOKER?	DECEASED?
			Pancreas Cancer: ☐ Yes ☐ No ☐Unknown **Diabetes:** ☐ Yes ☐ No ☐Unknown **Pancreatitis**: ☐ Yes ☐ No ☐Unknown Age(s) at Diagnosis:	☐ Yes ☐ No ☐ Unknown Type: Age at Diagnosis:	☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:
			Pancreas Cancer: ☐ Yes ☐ No ☐Unknown **Diabetes:** ☐ Yes ☐ No ☐Unknown **Pancreatitis**: ☐ Yes ☐ No ☐Unknown Age(s) at Diagnosis:	☐ Yes ☐ No ☐ Unknown Type: Age at Diagnosis:	☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:
			Pancreas Cancer: ☐ Yes ☐ No ☐Unknown **Diabetes:** ☐ Yes ☐ No ☐Unknown **Pancreatitis**: ☐ Yes ☐ No ☐Unknown Age(s) at Diagnosis:	☐ Yes ☐ No ☐ Unknown Type: Age at Diagnosis:	☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:
			Pancreas Cancer: ☐ Yes ☐ No ☐Unknown **Diabetes:** ☐ Yes ☐ No ☐Unknown **Pancreatitis**: ☐ Yes ☐ No ☐Unknown Age(s) at Diagnosis:	☐ Yes ☐ No ☐ Unknown Type: Age at Diagnosis:	☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:
			Pancreas Cancer: ☐ Yes ☐ No ☐Unknown **Diabetes:** ☐ Yes ☐ No ☐Unknown **Pancreatitis**: ☐ Yes ☐ No ☐Unknown Age(s) at Diagnosis:	☐ Yes ☐ No ☐ Unknown Type: Age at Diagnosis:	☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:
			Pancreas Cancer: ☐ Yes ☐ No ☐Unknown **Diabetes:** ☐ Yes ☐ No ☐Unknown **Pancreatitis**: ☐ Yes ☐ No ☐Unknown Age(s) at Diagnosis:	☐ Yes ☐ No ☐ Unknown Type: Age at Diagnosis:	☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:

*Smoker = >100 cigarettes in Lifetime

Use back of form if necessary.

21. Please fill in the table.

YOUR *FATHER'S* SIBLINGS

FULL NAME	GENDER (F/M)	DATE OF BIRTH Mo/Day/Yr	ANY PANCREAS PROBLEMS?	ANY OTHER CANCERS, INHERITED ANEMIAS OR DISORDERS?	*SMOKER?	DECEASED?
			Pancreas Cancer: ☐ Yes ☐ No ☐Unknown **Diabetes:** ☐ Yes ☐ No ☐Unknown **Pancreatitis**: ☐ Yes ☐ No ☐Unknown Age(s) at Diagnosis:	☐ Yes ☐ No ☐ Unknown Type: Age at Diagnosis:	☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:
			Pancreas Cancer: ☐ Yes ☐ No ☐Unknown **Diabetes:** ☐ Yes ☐ No ☐Unknown **Pancreatitis**: ☐ Yes ☐ No ☐Unknown Age(s) at Diagnosis:	☐ Yes ☐ No ☐ Unknown Type: Age at Diagnosis:	☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:
			Pancreas Cancer: ☐ Yes ☐ No ☐Unknown **Diabetes:** ☐ Yes ☐ No ☐Unknown **Pancreatitis**: ☐ Yes ☐ No ☐Unknown Age(s) at Diagnosis:	☐ Yes ☐ No ☐ Unknown Type: Age at Diagnosis:	☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:
			Pancreas Cancer: ☐ Yes ☐ No ☐Unknown **Diabetes:** ☐ Yes ☐ No ☐Unknown **Pancreatitis**: ☐ Yes ☐ No ☐Unknown Age(s) at Diagnosis:	☐ Yes ☐ No ☐ Unknown Type: Age at Diagnosis:	☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:
			Pancreas Cancer: ☐ Yes ☐ No ☐Unknown **Diabetes:** ☐ Yes ☐ No ☐Unknown **Pancreatitis**: ☐ Yes ☐ No ☐Unknown Age(s) at Diagnosis:	☐ Yes ☐ No ☐ Unknown Type: Age at Diagnosis:	☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:
			Pancreas Cancer: ☐ Yes ☐ No ☐Unknown **Diabetes:** ☐ Yes ☐ No ☐Unknown **Pancreatitis**: ☐ Yes ☐ No ☐Unknown Age(s) at Diagnosis:	☐ Yes ☐ No ☐ Unknown Type: Age at Diagnosis:	☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:

*Smoker = >100 cigarettes in Lifetime

Use back of form if necessary.

22. Do you have any other blood relatives (alive or deceased), ie. grandchildren or great-grandparents, who have been diagnosed with pancreas tumors or other cancer? (not listed in questions 17-22) ☐ Yes ☐ No If yes, please fill in the table below.

OTHER BLOOD RELATIVES

FULL NAME	GENDER (F/M)	RELATIONSHIP TO PATIENT	DATE OF BIRTH Mo/Day/Yr	Type of cancer, inherited anemia or disorder, date diagnosed, hospital where diagnosed or treated	*SMOKER?	DECEASED?
					☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:
					☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:
					☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:
					☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:
					☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:
					☐ Never ☐ Occasional ☐ Regular ☐ Unknown # Years Smoked: # Cigarettes/Day:	☐Yes ☐ No Date of Death: Cause of Death:

*Smoker = >100 cigarettes in Lifetime

23. Does your spouse have blood relatives with pancreas cancer? ☐ Yes ☐ No
If yes, please explain.

_____

_____

_____

_____

24. a. Have any family members had other tumors removed? ☐ Yes ☐ No
If yes, please describe type of tumor.

_____

_____

_____

_____

b. Were they treated with? ☐ Radiation Therapy ☐ Chemotherapy ☐ Surgery ☐ No Treatment

25. Are there any other conditions that run in your family that we should know about? (including Gardner's syndrome, hereditary pancreatitis, von Hippel-Lindau syndrome, Lynch syndrome, neurofibromatosis, familial atypical multiple mole melanoma syndrome)

_____

_____

_____

_____

26. Please check the box of the highest level of education of the following:

	Don't know	Grades 1-6	Grades 7-9	Grades 10-11	High school graduate	Some college	College graduate	Post-graduate degree
a. Yourself								
b. Your father								
c. Your mother								
d. Your spouse								

27. What is your current employment status?
Check the one that applies to the greatest percent of your time.

1 ☐ Employed
2 ☐ Homemaker
3 ☐ Retired
4 ☐ Disabled, unable to work
5 ☐ Unemployed
6 ☐ Student
7 ☐ Other

28. **Place a check in the box of the category of your usual occupation or job (the one you have worked at the longest).**

☐	**Management and Business Occupations**	Includes accountants, administrators, bankers, business owners, CEOs, company chairman, CPAs, economists, grocers, human resources, marketing managers, public relations, shop/store owners, sales managers, stock brokers.
☐	**Health care professionals, scientists, engineers**	Includes aerospace engineers, architects, biologists, biomedical engineers, biophysicists, chemists, child care workers, civil engineers, dentists, draftsmen, lab techs, LPNs, mathematicians, MDs, morticians, nurses aides, pharmacists, pharmacologists, physicists, radiology technicians, RNs, rocket scientists, social workers, statisticians, urban planners, veterinarians.
☐	**Lawyers and education professional**	Includes historians, insurance agents, judges, librarians, lawyers, map makers, ministers, paralegals, principals, professors, tax consultants, teachers.
☐	**Office support, sales personnel, communications personnel**	Includes advertising agents, art directors, cashiers, clerks, composers, journalists, key punch operators, mailroom personnel, news reporters, photographers, punch press operators, purchasing personnel, radio broadcasters, receptionists, real estate agents, sales persons (all types), secretaries, telephone operators, travel agents, TV directors, typists, writers editors.
☐	**Construction work, farming, fishing, forestry, installation, production, transportation**	Includes assembly line workers, auto repair, boilerman, brakeman, burner, construction workers and laborers, delivery drivers, electricians, electronic technicians, factory workers, farmers, fed ex drivers, florists, fork lift operators, fuelers, gardeners, gas station attendant, glass melting, housewasher, irrigation workers, item processing, lathe operator, lumberjacks, machinists, mason, mechanics, mold maker, milkman, oil riggers, pilots, pipe fitters, plumbers, printer, railroad workers, ranchers, roofers, sheet metal worker, ship captains, solderer, steamfitter, steel industry workers, textile cutters, textile worker, tool/die makers, train repair, truck drivers, TV techs, UPS drivers, wallpaper hangers, watermen, welders, well drillers.
☐	**Service workers**	Includes barbers, beauticians, butchers, butlers, casino dealers, clothing designer, cooks, custodians, fast food workers, housekeepers, housewives/homemakers, maids, seamstress.
☐	**Government workers, military, law enforcement**	Includes air force personnel, army, CIA, correctional officers, firemen, marines, navy, police, postal workers.
☐	**Computer technicians, production and support personnel**	Includes computer programmers, computer service personnel, program analysts.

Number of years in this job _____ What do/did you do on your job?_____

_____

In your work, do/did you spend more than 50% of the time ☐ indoors or ☐ outdoors?

29. In your work, were you exposed to any of the following <u>for a year or more</u>?

	YES	NO	DON'T KNOW
Arsenic			
Asbestos			
Asphalt			
Benzidine or betanaphthylamine			
Cadmium			
Chromium			
Coal			
DDT			
Dry cleaning agents			
Dyestuffs			
Heavy wood dust			
Herbicides			
Isopropyl oil			

	YES	NO	DON'T KNOW
Leather tanning chemicals			
Metal working fluids			
Nitrosamines			
Nickel			
Organophosphates			
PAH			
PCPs			
Pesticides			
Roofing chemicals (such as tar, soot, pitch, creosote)			
Rubber			
Styrene			
Vinyl chloride			
Uranium radiation			

30. Have you ever been exposed to residential radon? ☐ Yes ☐ No

If yes, was the radon level confirmed by a monitoring device or company? ☐ Yes ☐ No

31. Did you ever live in a neighborhood that was located near an industrial area? ☐ Yes ☐ No

If yes, where? _____

If yes, please estimate the number of years that you lived in that home: _____

32. a. Has a doctor ever told you that you have sugar diabetes (diabetes mellitus)? ☐ Yes ☐ No

b. If yes, how old were you? _____ Date: _____

Do/did you take insulin? ☐ Yes ☐ No

Do/did you take any medications by mouth to control your sugar?

_____

_____

33. a. Has a doctor ever told you that you have pancreatitis? ☐ Yes ☐ No

b. Have you ever had gallstones? ☐ Yes ☐ No

c. Have you ever had your gallbladder removed? ☐ Yes ☐ No

d. Have you ever had a pancreatic pseudocyst? ☐ Yes ☐ N0

e. Have you ever had celiac disease, sclerosing cholangitis, or gluten sensitive entropathy? ☐ Yes ☐ No

34. Please mark the box that best describes how much you drank of the following beverages in the last year:

BEVERAGE	HOW OFTEN									HOW MUCH			
	Never or less than once per month	1 - 3 per month	1 per week	2 - 4 per week	5 - 6 per week	1 per day	2 - 3 per day	4 - 5 per day	6+ per day	If a serving is:			
Beer										12 oz. can or bottle			
Wine or wine coolers										1 medium glass			
Hard Liquor (whiskey, gin, tequila, vodka)										1 shot (1 oz)			

THANK YOU VERY MUCH!

Please do not hesitate to call 215-955-9402 if you have any questions.

Jefferson Pancreas Tumor Registry
Department of Surgery
Thomas Jefferson University Hospital
1015 Walnut Street, 620 Curtis
Philadelphia, PA 19107

This document is based upon the questionnaire used by the Johns Hopkins National Familial Pancreas Tumor Registry, Baltimore, MD.