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:

☐ No ☐ Yes Cervical cancer? If YES, Year of diagnosis _____

☐ No ☐ Yes Cancer of the uterus? If YES, Year of diagnosis _____

BOTH MALE AND FEMALE:

☐ No ☐ Yes Other type of cancer? If YES, Year of diagnosis _____

Type: _____

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

☐ No ☐ Yes Goiter? If YES, Year of diagnosis _____

☐ No ☐ Yes Other type of thyroid disease? 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 _____

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

☐ No ☐ Yes Nephritis? If YES, Year of diagnosis _____

☐ No ☐ Yes Kidney Stones? If YES, Year of diagnosis _____

☐ No ☐ Yes Repeated kidney infections? If YES, Year of diagnosis _____

☐ No ☐ Yes Other kidney problems? If YES, Year of diagnosis _____

☐ No ☐ Yes Bladder problems? 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 _____