Fernald Community Cohort 2017 - Information Update
Please return this form in the postage prepaid envelope.

Your name (please print):_____**Your birthdate: ____/____/____**

Your signature: _____ **Today's Date: ____/____/____**

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 <u>ever</u> 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: _____

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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