BREAST MILK STUDY QUESTIONNAIRE

A. Reproductive Health

A1. At what age did you have your first menstrual period?

9 or younger 10 11 12 13 14 15 16

17 or older Don't know

A2. Have you menstruated since giving birth?

Yes No Don't know

A3. How many times have you been pregnant?

0 1 2 3 4 5 6 7 or more Don't know

A4. How many live births have you had?

0 1 2 3 4 5 6 7 or more Don't know

A5. Your age when you first gave birth _____

A5a. Your age when you last gave birth _____

A6. How many children have you breastfed?

1 2 3 4 5 6 7 or more Don't know

A7. How many months did you breastfeed each child?

First Child _____ months

Second Child _____ months

Third Child _____ months

Fourth Child _____ months

Fifth Child _____ months

Sixth Child _____ months

Seventh Child _____ months

A8. How old is the baby that you are breastfeeding? _____ weeks/months

A8a. Are you currently breastfeeding more than one child? If so, please note the ages of the other child(ren): _____ weeks/months _____ weeks/months _____ weeks/months

A9. Have you ever used birth control pills? Yes No

A9a. If yes, for how long? _____ months/years Don't know

A10. Are you currently taking birth control pills? Yes No Don't know

B. General Health

B1. Has a physician ever told you that you had any of these illnesses?

Cancer of the colon or rectum	Yes	No	
Cancer of the lung	Yes	No	
Melanoma	Yes	No	
Hodgkin's Disease	Yes	No	
Lymphoma	Yes	No	
Other Cancer	Yes	No	Specify _____

B2. Have you ever had radiation treatments for cancer or other illnesses?

Yes No

B3. Have you ever had chemotherapy treatments for cancer or other illnesses?

Yes No

B4. Have you ever had any breast biopsies or surgeries?

Yes No

B5. Are you currently taking any prescription medication?

Yes No

B6. Thinking back over the past week, have you taken any over-the-counter pain relievers?

Yes No Don't know

B7. Thinking back over the past month, have you taken any over-the-counter vitamins, supplements, or herbs?

Yes No Don't know

B8. Have you have had a cold or flu in the last several weeks?

Yes No If yes, when? _____

C. About You

C1. Do you presently smoke cigarettes?

Yes No

C2. Thinking back over your entire lifetime, have you smoked a total of 100 cigarettes or more?

Yes No Don't know

C2a. If yes, have you ever smoked at least one cigarette per day for six months or longer?

Yes No Don't know

C3. How old were you when you last smoked at least one cigarette per day? _____

C4. Compared to when you were younger, do you smoke more or less now?

More Less Don't know

C5. Does anyone else in your household smoke?

Yes No

C6. What is your age? _____

C7. What is your current occupation? _____

C8. How would you best describe your ethnic background? _____

C9. Do you consider yourself to be of Latina origin?

Yes No

C10. Which of the following best describes your racial background?

__ White __ Black, African-American

__ Asian/Pacific Islander __ Native American

__ Hispanic __ Other: specify _____

C11. In what city and state do you currently live? _____

C12. How long have you lived at this location? _____

C13. If you have lived at your present location for less than 5 years, where else have you lived? _____

C14. What brand of breast pump was used to express the milk? _____

C15. Please record your weight and height: Wt _____ Ht _____

D. About Your Family

D1. Have you or any of your blood relatives ever had breast cancer?

Self Yes No

Mother Yes No Don't know

Father	Yes	No	Don't know
Sister	Yes	No	Don't know
Daughter	Yes	No	Don't know
Maternal Grandparent	Yes	No	Don't know
Paternal Grandparent	Yes	No	Don't know
Maternal Aunt	Yes	No	Don't know
Paternal Aunt	Yes	No	Don't know
Other	Yes	No	Don't know

D2. Have you or any of your blood relatives ever had ovarian cancer?

Self	Yes	No	
Mother	Yes	No	Don't know
Sister	Yes	No	Don't know
Daughter	Yes	No	Don't know
Maternal Grandmother	Yes	No	Don't know
Paternal Grandmother	Yes	No	Don't know
Maternal Aunt	Yes	No	Don't know
Paternal Aunt	Yes	No	Don't know
Other	Yes	No	Don't know

How did you hear about this study?

Flyer

OB/GYN _____

Personal contact

Other _____

Time and date milk expressed: _____

Time and date milk collected: _____

Thank you very much for your participation in this study.