

# Participant Questionnaire

## Instructions for Participants:

It is important that we collect some voluntary information to help researchers best utilize your blood donation. Please complete the following questions and contact us if you need any help (403.521.3249). All questions are voluntary; if you do not wish to answer a question, please write **N/A** next to the question. All information provided to the study team will be coded and de-identified; no identifiable information about your identity will be shared.

**Thank you for your help!**

**Participant ID (for office use only)**

**Sample ID (for office use only)**

**Date of Blood Donation** (dd/mm/yyyy)   /   /

**1. Age** (years)         **2. Weight** (lbs)            **3. Height** ('")

**4. Ethnicity** - Please check the box which best describes your ethnicity

- |  |                                       |
|--|---------------------------------------|
| <input type="checkbox"/> Caucasian                     | <input type="checkbox"/> Asian        |
| <input type="checkbox"/> Indigenous or Native American | <input type="checkbox"/> South Asian  |
| <input type="checkbox"/> African                       | <input type="checkbox"/> East Asian   |
| <input type="checkbox"/> Unsure                        | <input type="checkbox"/> Middle Asian |
| <input type="checkbox"/> Other: _____                  |                                       |

**5. Smoking status**

- Current smoker      If yes, for how long (years)
- Former smoker      If yes, for how long (years)
- Never smoker

**6. Menstrual status**

Are you pre-menopausal?       Post-menopausal?

Approximately when was your last menstrual period?

less than 6 months ago

↳ Please specify first day of last menstrual period:   /   /     (dd / mm / yyyy)

between 6 and 12 months ago

more than 12 months ago

don't know



Have you ever had an operation to remove both of your ovaries (this may have been at the same time as a hysterectomy)?

- Yes —→ if yes, approximate date of surgery  
 No  
 Don't know  
 Only one ovary removed

(mm / yy)  
 /

### 7. Hormone Replacement Therapy (HRT):

Have you ever used Hormone Replacement Therapy? Yes  No

If yes, for how long? Please select one of the following:

- < 1 year  
 1-3 years  
 4-6 years  
 7-10 years  
 Longer than 10 years

Do you still use HRT? Yes  No

If yes, please document name and dosage of medication:

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### 8. Hormone-based Birth Control:

Have you ever used hormone-based birth control (in the form of a pill, patch or an injection)? Yes  No

If yes, for how long? Please select one of the following:

- < 1 year  
 1-3 years  
 4-6 years  
 7-10 years  
 Longer than 10 years

Do you still use this method of birth control? Yes  No

### 9. Breast-feeding status and/or history:

Number of children:  Age at first childbirth:  Number of children breastfed:

Approximate **total** length of breast-feeding for all children:


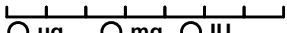
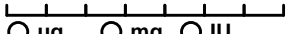
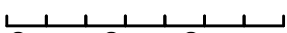

- < 3 months  
 4-6 months  
 7-9 months  
 10-12 months  
 1-2 years  
 > 2 years



10 Have any of your relatives, specifically your parents, siblings or children, ever been diagnosed with cancer?  yes  no  don't know   
 if yes, please fill out the following table

	Type of Relative	Type of Cancer	Approximate Age at Diagnosis
1.	<input type="radio"/> Parent <input type="radio"/> Sibling <input type="radio"/> Child		<input type="radio"/> age 50 or younger <input type="radio"/> older than age 50 <input type="radio"/> don't know
2.	<input type="radio"/> Parent <input type="radio"/> Sibling <input type="radio"/> Child		<input type="radio"/> age 50 or younger <input type="radio"/> older than age 50 <input type="radio"/> don't know
3.	<input type="radio"/> Parent <input type="radio"/> Sibling <input type="radio"/> Child		<input type="radio"/> age 50 or younger <input type="radio"/> older than age 50 <input type="radio"/> don't know
4.	<input type="radio"/> Parent <input type="radio"/> Sibling <input type="radio"/> Child		<input type="radio"/> age 50 or younger <input type="radio"/> older than age 50 <input type="radio"/> don't know
5.	<input type="radio"/> Parent <input type="radio"/> Sibling <input type="radio"/> Child		<input type="radio"/> age 50 or younger <input type="radio"/> older than age 50 <input type="radio"/> don't know

11 If you have taken any medications, vitamins or herbal supplements in the past 72 hours (prior to having your blood drawn), please fill out the following table (continue on a separate sheet if required). **Do not stop taking medications or vitamins unless otherwise instructed.**

Name of Medication, Vitamin or Herbal Supplement	Dose (. / allowed)	Date of Last Dose (dd/mm/yyyy)	Time of Last Dose (24 Hour)
	 <input type="radio"/> ug <input type="radio"/> mg <input type="radio"/> IU <input type="radio"/> other $\longrightarrow$ _____	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/>
	 <input type="radio"/> ug <input type="radio"/> mg <input type="radio"/> IU <input type="radio"/> other $\longrightarrow$ _____	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/>
	 <input type="radio"/> ug <input type="radio"/> mg <input type="radio"/> IU <input type="radio"/> other $\longrightarrow$ _____	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/>
	 <input type="radio"/> ug <input type="radio"/> mg <input type="radio"/> IU <input type="radio"/> other $\longrightarrow$ _____	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/>
	 <input type="radio"/> ug <input type="radio"/> mg <input type="radio"/> IU <input type="radio"/> other $\longrightarrow$ _____	<input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> / <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> : <input type="text"/> <input type="text"/>

Please indicate if an additional sheet was used to record medications by placing a checkmark in the box.



**Thank you for your participation!**

