

Genetic Determinants of Barrett's Esophagus and Esophageal Adenocarcinoma

Family Number _____

Please fill in your NAME, ADDRESS, and TELEPHONE NUMBER in the space below:

IF YOU ARE ON MEDICATIONS, ANSWER ALL QUESTIONS ABOUT SYMPTOMS AS TO WHAT YOU WOULD FEEL IF YOU WERE NOT TAKING MEDICATIONS.

First, we have some questions about **HEARTBURN**. The term "heartburn" means a burning pain or discomfort behind the breastbone in your chest. When answering these questions, please do not count any other sensation as heartburn. Heartburn does NOT refer to pain in your stomach or pain from heart trouble.

1. Have you had heartburn in the last year? (Check one)
 - No → Please go to question #8 on page 2.
 - Yes → Please answer the following questions.

2. When in your life did this heartburn FIRST begin as close as you can recall? (Check one)
 - In the past year
 - More than 1 year less than 5 years ago
 - More than 5 years less than 10 years ago
 - More than 10 years ago

3. Exactly what year did it start? (Give your best estimate.) _____

4. How frequently have you had heartburn in the last year? (Check one)
 - Less than once a month
 - About once a month
 - About once a week
 - Several times a week
 - Every day

5. How bad is your usual heartburn? (Check one)
 - MILD – can be ignored if I don't think about it
 - MODERATE – cannot be ignored, but does not affect my life-style
 - SEVERE – affects my life style

6. Has your heartburn awakened you at night in the last year? (Check one)
 - No
 - Yes

7. Is your heartburn usually made better (eased) by taking antacids (like Amphogel, Alternagel, Gaviscon, Maalox, Mylanta, Riopan, Rolaids, or Tums)? (Check one)
 - No
 - Yes
 - I have not taken antacids for heartburn

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Next, we would like to ask questions about **ACID REGURGITATION**. Acid regurgitation is a bitter or sour tasting liquid coming up into your mouth or throat.

8. Have you had acid regurgitation in the last year? (Check one)
- No → Please go to question #15 on page 3.
 - Yes → Please answer the following questions.
9. When in your life did this acid regurgitation FIRST begin as close as you can recall? (Check one)
- In the past year
 - More than 1 year less than 5 years ago
 - More than 5 years less than 10 years ago
 - More than 10 years ago
10. Exactly what year did it start? (Give your best estimate.) _____
11. How frequently have you had acid regurgitation in the last year? (Check one)
- Less than once a month
 - About once a month
 - About once a week
 - Several times a week
 - Every day
12. How bad is your usual acid regurgitation? (Check one)
- MILD – can be ignored if I don't think about it
 - MODERATE – cannot be ignored, but does not affect my life-style
 - SEVERE – affects my life style
13. Has your acid regurgitation awakened you at night in the last year? (Check one)
- No
 - Yes
14. Is your acid regurgitation usually made better (eased) by taking antacids (like Amphogel, Alternagel, Gaviscon, Maalox, Mylanta, Riopan, Rolaid, or Tums)? (Check one)
- No
 - Yes
 - I have not taken antacids for acid regurgitation

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Next, we would like to ask you some questions about **TROUBLE SWALLOWING**. Trouble swallowing refers to the feeling that food sticks in your throat or chest.

15. Have you had trouble swallowing in the last year? (Check one)
- No → Please go to question #23 on page 4.
 - Yes → Please answer the following questions.
16. When in your life did this trouble swallowing FIRST begin as close as you can recall? (Check one)
- In the past year
 - More than 1 year less than 5 years ago
 - More than 5 years less than 10 years ago
 - More than 10 years ago
17. Exactly what year did it start? (Give your best estimate.) _____
18. How frequently have you had trouble swallowing in the last year? (Check one)
- Less than once a month
 - About once a month
 - About once a week
 - Several times a week
 - Every day
19. How bad is your usual trouble swallowing? (Check one)
- MILD – can be ignored if I don't think about it
 - MODERATE – cannot be ignored, but does not affect my life-style
 - SEVERE – affects my life style
20. Does it hurt when you swallow? (Check one)
- No
 - Yes
21. What do you have trouble swallowing? (Check one)
- Solid foods only
 - Liquids only
 - Both solid foods and liquids
22. Do you have trouble swallowing with every meal? (Check one)
- No
 - Yes

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23. Have you taken any of the following medications in the last year?

	No	Yes		No	Yes
Antacids	<input type="checkbox"/>	<input type="checkbox"/>	Axid (nizatidine)	<input type="checkbox"/>	<input type="checkbox"/>
Carafate (sucralfate)	<input type="checkbox"/>	<input type="checkbox"/>	Prevacid (lansoprazole)	<input type="checkbox"/>	<input type="checkbox"/>
Prilosec (omeprazole)	<input type="checkbox"/>	<input type="checkbox"/>	Propulsid (cisapride)	<input type="checkbox"/>	<input type="checkbox"/>
Reglan (metoclopramide)	<input type="checkbox"/>	<input type="checkbox"/>	Tagamet (cimetidine)	<input type="checkbox"/>	<input type="checkbox"/>
Zantac (ranitidine)	<input type="checkbox"/>	<input type="checkbox"/>	Nexium (esomeprazole)	<input type="checkbox"/>	<input type="checkbox"/>
Aciphex (rabeprazole)	<input type="checkbox"/>	<input type="checkbox"/>	Protonix (pantoprazole)	<input type="checkbox"/>	<input type="checkbox"/>

24. Did you ever smoke cigarettes regularly (at least one cigarette per day for at least 30 days)? (Check one)

- No
 Yes

25. At what age did you start? _____

26. When smoking the heaviest, how many packs did you smoke per day? _____

27. How many packs per day do you currently smoke? _____

28. If you stopped smoking, at what age did you stop? _____

29. Do you drink coffee? (Check one)

- No
 Yes

30. Usually decaffeinated or regular? _____

31. How many cups per day on the average? _____

32. How many alcoholic drinks a week have you had on the average in the last year? (Check one) (One drink = 12 oz beer, 4 oz wine, or 1½ oz of liquor)

- Less than one drink a week
 1 to 5 drinks a week
 6 to 10 drinks a week
 More than 10 drinks a week

33. Your gender: Male Female

34. Current marital status. (Check one)

- Married
 Single
 Widowed
 Divorced
 Separated
 Other _____

35. What is your date of birth?

Month |__|__| Day |__|__| Year 19|__|__|

36. Please indicate your highest level of educational training. (Check one)

- Professional training beyond college
 College graduate
 High school graduate
 Less than high school

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37. Present status: (Check one)
- Employed What kind of work? _____
 - Unemployed
 - Retired
 - Full-time homemaker
 - Full-time student
 - Disabled
38. Which of these categories **best** describes you. (Check only one)
- African-American or black
 - American Indian
 - Asian or Asian American
 - Caucasian or white
 - Hispanic or Mexican
 - Other (list) _____
39. How tall are you in your stocking feet? |__| FEET |__|__| INCHES
40. What is your current weight? |__|__|__| POUNDS

For the following questions, we are interested in your weight throughout your adult life. If you were under 18 years of age for any of the following time periods, please circle "less than 18 years old".

41. What was your weight one year ago? |__|__|__| POUNDS **OR** less than 18 y.o.
42. What was your weight 5 years ago |__|__|__| POUNDS **OR** less than 18 y.o.
43. What was your weight 10 years ago? |__|__|__| POUNDS **OR** less than 18 y.o.
44. What was your weight 20 years ago? |__|__|__| POUNDS **OR** less than 18 y.o.
45. Have you ever had (biological) children? (check one)
- No
 - Yes If yes, then: _____ daughters and _____ sons.
46. Is your spouse the birth (biological) parent of your children? (check one)
- No
 - Yes
47. Are your parents related to each other by blood? (check one)
- No
 - Yes
- If yes, how are they related? (for example, first or second cousins): _____
48. Do you have any biological (blood) brothers or sisters? (check one)
- No
 - Yes
- If yes, then: _____ brothers and _____ sisters.
49. Do you have any biological relatives?
- Yes
 - No

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- Please answer the following questions as completely as possible.
- Answer the questions for yourself and your biological or blood relatives.
- If you are adopted, only answer the questions about your birth family.
- If you are not sure of the correct answer, please give us your best guess.

Please answer the following questions about yourself:

50. Has a doctor ever told you that you had cancer of the esophagus? (check one) (The esophagus is the tube that carries food from your mouth to your stomach)

No

Yes How old were you? _____ years

If yes, please list name and location of hospital and name of doctor to the best of your recollection

51. Has a doctor ever told you that you had Barrett's esophagus (an abnormal lining of your esophagus)? (check one)

No

Yes How old were you? _____ years

If yes, please list name and location of hospital and name of doctor to the best of your recollection

52. Have you ever had an examination of the esophagus? (check one)

No

Yes

If yes, did you have a:

a. Barium Swallow Yes No Year _____

b. Upper GI Yes No Year _____

(These are tests where you drink white, chalky liquid, and then x-rays are taken)

c. Upper Endoscopy (EGD) Yes No Year _____

(This is a test where you are given a medication to make you sleepy and then a tube with a tiny camera is placed through your mouth and into your stomach)

If you had endoscopy, please list name and location of hospital and name of doctor to the best of your recollection

53. Other than listed above, has a doctor ever told you that you have had other cancers? (check one)

No

Yes

If yes, what type of cancer?

Cancer 1: _____ at age _____ years

Cancer 2: _____ at age _____ years

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Please check with your family and answer the following questions about your biological (blood) relatives only. Include your immediate family, grandparents, uncles, aunts, cousins, half brothers, and half sisters. Do not include your spouse or spouse's relatives.

54. Have any of your blood relatives had cancer of the esophagus? (check one)

No

Yes

55. Have any of your blood relatives had Barrett's esophagus (check one)

No

Yes

56. Have any of your blood relatives had other cancers?

No

Yes

If yes, list types of cancers:

Cancer 1: _____

Cancer 2: _____

Cancer 3: _____

Cancer 4: _____

Cancer 5: _____

Cancer 6: _____

Cancer 7: _____

Cancer 8: _____

57. Do you personally have diabetes?

No

Yes

58. Do you use insulin to treat your diabetes?

No

Yes

59. Do you use metformin to treat your diabetes?

No

Yes

60. Do you use other medications for your diabetes?

No

Yes: (List medications _____)

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LEAVE THE FOLLOWING SECTION BLANK (The Study Coordinator will take these measurements and fill out this section)

61. Measured Waist Circumference _____ cm.

62. Measured Hip Circumference _____ cm.

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PLEASE ASK YOUR RELATIVES (INCLUDING YOUR SPOUSE) IF THEY WOULD BE WILLING TO PARTICIPATE IN THIS RESEARCH STUDY. THEY WILL RECEIVE THE SAME QUESTIONNAIRE, IF THEY ARE WILLING TO PARTICIPATE. WE MIGHT ALSO RECOMMEND AN ENDOSCOPY, WHICH COULD BE PERFORMED AT UNIVERSITY HOSPITALS OF CLEVELAND FREE OF CHARGE. IN THE FUTURE, WE MIGHT ALSO ASK THEM IF THEY WOULD BE WILLING TO DONATE BLOOD AND/OR TISSUE FOR OUR RESEARCH.

PLEASE GIVE US CONTACT INFORMATION FOR YOUR RELATIVES IN THE FOLLOWING PAGES ONLY IF THEY AGREE TO BEING CONTACTED.

(WE MIGHT CONTACT YOU BY TELEPHONE TO GET INFORMATION ABOUT YOUR RELATIVES ALSO.)

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Please answer the following questions about your birth family:

List the names, addresses, and phone numbers of your **natural (biological) children** below.

<i>Name, Address, and Phone Number:</i>	Birth date or year	Sex M/F	Alive? Y/N
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

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Please complete the following information about your **spouse**.

<i>Name, Address, and Phone Number:</i>	Birth date or year	Sex M/F	Alive? Y/N

List the names, addresses, and phone numbers of your **parents**.

<i>Name, Address, and Phone Number:</i>	Birth date or year	Alive? Y/N
Mother:		
Father:		

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List the names, addresses, and phone numbers of your **biological brothers and sisters**.

<i>Name, Address, and Phone Number:</i>	Birth date or year	Sex M/F	Alive? Y/N
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

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List the names, addresses, and phone numbers of any other **blood relatives**, other than the ones already **listed**, who would be interested in participating in our research.

<i>Name, Address, and Phone Number:</i>	Birth date or year	Sex M/F	Relationship (Paternal aunt, maternal cousin, etc.)	Alive? Y/N
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

Please do not include any contact information or clearly indicate with a large “Ø” next to any relative who you **do not** want us to contact.