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Online™

Study of Osteoporotic Fractures (SOF)

Study Collection Forms

Visit 4

Medical History

Cancer History

Form Type: Self-Administered Questionnaire

LEGEND:

Raw form variable names are located next to the question they represent and do not have a border around the variable name.

Calculated variable names are derived from other variables and have a border around the variable name. The calculated variables names are located in close proximity to the questions from which they were derived.

Some of the questions and measurements on these forms are not being released, and therefore no variable name is provided for them.

Extended Medical History

45. Has a doctor **EVER** told you that you have cancer?

V4ECANCR

Yes

No

Don't
know

PLEASE GO TO QUESTION 46

If yes, please specify the kind of cancer(s).
(Check all that apply.)

IF YES,
are you currently
being treated for
this cancer by a
doctor?

V4EBC

- | | | | | |
|---|-----------------------------|--------------------------------|-----------------------------|------------------------------|
| a. Breast cancer | <input type="checkbox"/> No | <input type="checkbox"/> Yes → | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| b. Colon (bowel) or
rectum cancer | <input type="checkbox"/> No | <input type="checkbox"/> Yes → | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| c. Lung cancer | <input type="checkbox"/> No | <input type="checkbox"/> Yes → | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| d. Skin cancer | <input type="checkbox"/> No | <input type="checkbox"/> Yes → | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| e. Cancer of the uterus
(womb), endometrial cancer | <input type="checkbox"/> No | <input type="checkbox"/> Yes → | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| f. Ovarian cancer | <input type="checkbox"/> No | <input type="checkbox"/> Yes → | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| g. Cancer of the cervix | <input type="checkbox"/> No | <input type="checkbox"/> Yes → | <input type="checkbox"/> No | <input type="checkbox"/> Yes |
| h. Other: _____ | <input type="checkbox"/> No | <input type="checkbox"/> Yes → | <input type="checkbox"/> No | <input type="checkbox"/> Yes |