

# CEGIIR Study – Questionnaire

Sep 22, 2008.

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***Section 1: Patient Information***

**Patient Information**

1.1. Interview Date: (automatically entered)

1.2. Site: (automatically entered)

1.3. First Name: \_\_\_\_\_

1.4. Last name: \_\_\_\_\_

1.5. Alberta Health Care #: \_\_\_\_\_

1.6. Date of birth: \_\_/\_\_/\_\_\_\_ (dd-mm-yyyy) (drop-down for day and month)

1.7. Gender:  Male  Female

1.8. Number of siblings (NOT adopted): Total Brothers: \_\_\_\_\_ Total Sisters: \_\_\_\_\_

1.9. Postal Code: \_\_\_\_\_

1.10a. Where were you born? \_\_\_\_(drop-down menu)\_\_\_\_

If Canada, Province/Territory: \_\_\_\_(drop-down menu)\_\_\_\_

1.10b. Where was your father born? \_\_\_\_(drop-down menu)\_\_\_\_

If Canada, Province/Territory: \_\_\_\_(drop-down menu)\_\_\_\_

1.10c. Where was your mother born? \_\_\_\_(drop-down menu)\_\_\_\_

If Canada, Province/Territory: \_\_\_\_(drop-down menu)\_\_\_\_

## Patient Information

1.11. Cultural and genetic factors can have an important influence on health, so we'd like to ask you about your background.

1.11a. Which genetic (blood-line or biological ancestry) population group(s) best describe you? (Please indicate all that apply)

- Aboriginal (North American Indian/First Nations, Metis, or Inuit/Eskimo)
- Arab
- Black
- Chinese
- Filipino
- Hutterite
- Japanese
- Jewish-Ashkenazi
- Jewish-Sephardic
- Korean
- Latin American
- South Asian (e.g., East Indian, Pakistani, Sri Lankan, etc.)
- Southeast Asian (e.g., Cambodian, Indonesian, Laotian, Vietnamese, etc.)
- West Asian (e.g., Afghan, etc.)
- White (European Ancestry)
- Other; Please specify : \_\_\_\_\_

## Patient Information

1.11a. Continue ...

If aboriginal, are you .....? (Please indicate all that apply)

- Inuit (Eskimo)
- Métis
- North American Indian (First Nations)
- Treaty or Registered
- Other: \_\_\_\_\_

If North American Indian(First nations), are you.....?

Member of an Indian Band/First nation?

- Yes
- No

If Yes to above:

Please specify Band or First Nation: \_\_\_\_\_

## Patient Information

1.11b. Is your genetic or biological ancestry the same as the ethnic group or culture you were raised in?

- Yes
- No

If no, which population group(s) best describe the culture you were raised in? (Please indicate all that apply)

- Aboriginal, Specify if:
  - Inuit (Eskimos)
  - Métis
  - North American Indian (First Nations)
- Arab
- Black
- Chinese
- European ancestry, specify (e.g. English, Ukrainian, etc.): \_\_\_\_\_
- Filipino
- Hutterite
- Japanese
- Jewish-Ashkenazi
- Jewish-Sephardic
- Korean
- Latin American
- South Asian (e.g., East Indian, Pakistani, Sri Lankan, etc.)
- Southeast Asian (e.g., Cambodian, Indonesian, Laotian, Vietnamese, etc.)
- West Asian (e.g., Afghan, etc.)
- Other; Please specify: \_\_\_\_\_

## Patient Information

1.12. If you or your ancestors immigrated to North America, which generation of your family immigrated? As far as you know, was it .....

- Yourself; Please specify how many years ago : \_\_\_\_\_
- One or more parents
- One or more grandparents
- One or more great-grandparents
- One or more ancestors from an earlier generation
- N/A (i.e. Not immigrated)
- Do not know

## Patient Information

1.13a. To Which ethnic or cultural group(s) did your mother's ancestors belong? (Please indicate all that apply)

- |                                      |   |   |                                     |
|--------------------------------------|---|---|-------------------------------------|
| <input type="checkbox"/> Austrian    | <input type="checkbox"/> French             | <input type="checkbox"/> N. American Indian | <input type="checkbox"/> Spanish    |
| <input type="checkbox"/> Chinese     | <input type="checkbox"/> German             | <input type="checkbox"/> Norwegian          | <input type="checkbox"/> Swedish    |
| <input type="checkbox"/> Danish      | <input type="checkbox"/> Hungarian (Magyar) | <input type="checkbox"/> Polish             | <input type="checkbox"/> Swiss      |
| <input type="checkbox"/> Dutch       | <input type="checkbox"/> Irish              | <input type="checkbox"/> Romanian           | <input type="checkbox"/> Ukrainian  |
| <input type="checkbox"/> East Indian | <input type="checkbox"/> Italian            | <input type="checkbox"/> Russian            | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> English     | <input type="checkbox"/> Lebanese           | <input type="checkbox"/> Scottish           | <input type="checkbox"/> Welsh      |
| <input type="checkbox"/> Filipino    | <input type="checkbox"/> Métis              |   |                                     |
- American/USA - not otherwise known  
 Canadian - not otherwise known  
 Other; Please specify: \_\_\_\_\_

## Patient Information

1.13b. To which ethnic or cultural group(s) did your father's ancestors belong? (Please indicate all that apply)

- |                                      |   |   |                                     |
|--------------------------------------|---|---|-------------------------------------|
| <input type="checkbox"/> Austrian    | <input type="checkbox"/> French             | <input type="checkbox"/> N. American Indian | <input type="checkbox"/> Spanish    |
| <input type="checkbox"/> Chinese     | <input type="checkbox"/> German             | <input type="checkbox"/> Norwegian          | <input type="checkbox"/> Swedish    |
| <input type="checkbox"/> Danish      | <input type="checkbox"/> Hungarian (Magyar) | <input type="checkbox"/> Polish             | <input type="checkbox"/> Swiss      |
| <input type="checkbox"/> Dutch       | <input type="checkbox"/> Irish              | <input type="checkbox"/> Romanian           | <input type="checkbox"/> Ukrainian  |
| <input type="checkbox"/> East Indian | <input type="checkbox"/> Italian            | <input type="checkbox"/> Russian            | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> English     | <input type="checkbox"/> Lebanese           | <input type="checkbox"/> Scottish           | <input type="checkbox"/> Welsh      |
| <input type="checkbox"/> Filipino    | <input type="checkbox"/> Métis              |   |                                     |
- American/USA - not otherwise known  
 Canadian - not otherwise known  
 Other; Please specify: \_\_\_\_\_

## Patient Information

1.14. Are you a twin (or triplets, quadruplets, etc)?

- Yes
- No

If yes, do your siblings from the same pregnancy all have same gender?

- Yes
- No

1.15. What is the highest level of education you completed? (Select ONLY one answer.)

- None or just kindergarten
- Less than high school; specify highest grade completed (1 to 13): \_\_\_\_\_
- Secondary (high) school graduation certificate or equivalent
- Beyond high school other than university with no certificate or diploma; (e.g., trade school, community college, CEGEP, etc.) number of years beyond high school: \_\_\_\_\_
- Trades certificate or diploma
- Other non-university certificate or diploma (e.g., community college, CEGEP, tech institute)
- Some university with no certificate or diploma; number of years: \_\_\_\_\_
- University certificate or diploma below bachelor's
- University degree – bachelor's
- University certificate above bachelor's
- Some graduate school, no degree or certificate completed; number of years: \_\_\_\_\_
- Graduate/professional degree

1.16. Name of Doctor who you are visiting today:      (drop-down menu)

## ***Section 2: Family History***

***Section 2.1: Family History - Disease***

**Family History – Disease** (Click on underlined text will show definitions of the disease.)

Has anyone in your immediate (birth, biological, related) family ever had the following disease(s)? (Please indicate all that apply)

(\*Note\* Immediate Family includes the following: Father, Mother, Sister, Brother, Son, Daughter, Father's father, Mother's father, Father's mother, Mother's mother)

**Bowel Diseases**

- Celiac Disease
- Crohn's Disease
- Irritable Bowel Disease
- Ulcerative Colitis
- Ulcer Disease
- Unknown
- Other: \_\_\_\_\_
- N/A

**AutoImmune Diseases**

- Asthma
- Grave Disease
- Hypothyroidism
- Juvenile Diabetes
- Lupus Erythematosus
- Multiple Sclerosis
- Psoriasis
- Rheumatoid Arthritis
- Sjogren Syndrome
- Unknown
- Other: \_\_\_\_\_
- N/A

**Liver Diseases**

- Alcohol Cirrhosis
- Autoimmune Hepatitis
- Fatty Liver NASH
- Hemochromatosis
- Hepatitis B
- Hepatitis C
- Primary Biliary Cirrhosis (PBC)
- Primary Sclerosing Cholangitis (PSC)
- Wilson Disease
- Unknown
- Other: \_\_\_\_\_
- N/A

Or,

- I am adopted, and I do not know the disease history of my biological (birth and/or blood related) family.

## Family History – Disease

2.1.1. Who in your immediate (birth, biological, related) family has ever had Unknown Bowel Diseases? (Please indicate all that apply)

- Father
- Mother
- Brothers      If yes, how many brothers had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Sisters         If yes, how many sisters had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Sons             If yes, how many sons had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Daughters      If yes, how many daughters had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Father's Father
- Father's Mother
- Mother's Father
- Mother's Mother
  
- Spouse/Common law

## Family History – Disease

2.1.2. Who in your immediate (birth, biological, related) family has ever had Unknown AutoImmune Diseases? (Please indicate all that apply)

- Father
- Mother
- Brothers      If yes, how many brothers had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Sisters        If yes, how many sisters had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Sons            If yes, how many sons had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Daughters     If yes, how many daughters had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Father's Father
- Father's Mother
- Mother's Father
- Mother's Mother
  
- Spouse/Common law

## Family History – Disease

2.1.3. Who in your immediate (birth, biological, related) family has ever had Celiac Disease? (Please indicate all that apply)

- Father
- Mother
- Brothers      If yes, how many brothers had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Sisters        If yes, how many sisters had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Sons            If yes, how many sons had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Daughters     If yes, how many daughters had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Father's Father
- Father's Mother
- Mother's Father
- Mother's Mother
  
- Spouse/Common law

## Family History – Disease

2.1.4. Who in your immediate (birth, biological, related) family has ever had Grave Disease? (Please indicate all that apply)

- Father
- Mother
- Brothers      If yes, how many brothers had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Sisters        If yes, how many sisters had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Sons            If yes, how many sons had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Daughters     If yes, how many daughters had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Father's Father
- Father's Mother
- Mother's Father
- Mother's Mother
  
- Spouse/Common law

## Family History – Disease

2.1.5. Who in your immediate (birth, biological, related) family has ever had AutoImmune Hepatitis? (Please indicate all that apply)

- Father
- Mother
- Brothers      If yes, how many brothers had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Sisters        If yes, how many sisters had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Sons            If yes, how many sons had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Daughters     If yes, how many daughters had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Father's Father
- Father's Mother
- Mother's Father
- Mother's Mother
  
- Spouse/Common law

***Section 2.2: Family History - Cancer***

## Family History – Cancer

Has anyone in your immediate (birth, biological, related) family ever had the following cancer(s)? (Please select all that apply)

(\*Note\* Immediate Family includes the following: Father, Mother, Sister, Brother, Son, Daughter, Father's father, Mother's father, Father's mother, Mother's mother)

- Colon cancer
- Esophageal cancer
- Gallbladder
- Leukemia
- Liver/bile duct cancer
- Lymphoma
- Mouth cancer
- Small bowel cancer
- Stomach cancer
- Unknown
- Other: \_\_\_\_\_
- N/A

Or,

- I am adopted, and I do not know the cancer history of my biological (birth and/or blood related) family.

## Family History – Cancer

2.2.1. Who in your immediate (birth, biological, related) family has ever had Unknown cancer?

- Father
- Mother
- Brothers      If yes, how many brothers had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Sisters        If yes, how many sisters had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Sons            If yes, how many sons had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Daughters     If yes, how many daughters had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Father's Father
- Father's Mother
- Mother's Father
- Mother's Mother
  
- Spouse/Common law

## Family History – Cancer

2.2.2. Who in your immediate (birth, biological, related) family has ever had Mouth cancer?

- Father
- Mother
- Brothers      If yes, how many brothers had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Sisters         If yes, how many sisters had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Sons             If yes, how many sons had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Daughters      If yes, how many daughters had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Father's Father
- Father's Mother
- Mother's Father
- Mother's Mother
  
- Spouse/Common law

## Family History – Cancer

2.2.3. Who in your immediate (birth, biological, related) family has ever had Leukemia?

- Father
- Mother
- Brothers      If yes, how many brothers had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Sisters        If yes, how many sisters had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Sons            If yes, how many sons had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Daughters     If yes, how many daughters had this disease? \_\_\_\_\_ (drop-down box, options: 1,2,3, and >3)
- Father's Father
- Father's Mother
- Mother's Father
- Mother's Mother
  
- Spouse/Common law

***Section 3: Smoking History***

## Smoking History

3.1a. Do you currently use any non-pharmaceutical tobacco products other than cigarette smoking? (e.g. pipe, chewing tobacco, snuff products)

- Yes
- No

3.1b. In a typical week, during how much time, according to your best estimate, are you in the presence of other people smoking cigarettes or otherwise exposed to cigarette smoke from other people?

- None
- >0 but <1 hour per week
- 1-3 hours per week
- 4-6 hours per week
- 1-2 hours per day
- >2 hours per day

### Smoking History

3.2a. Have you smoked cigarettes in the past?

- Yes
- No

If yes, please fill in below the most recent 3 periods and the average number of packs you smoked cigarettes in the past:

Dates		Packs/Day				
From	(year) to (year)	<input type="checkbox"/> 1/2 pack	<input type="checkbox"/> 1 pack	<input type="checkbox"/> 2 packs	<input type="checkbox"/> 3 packs	<input type="checkbox"/> N/A
From	(year) to (year)	<input type="checkbox"/> 1/2 pack	<input type="checkbox"/> 1 pack	<input type="checkbox"/> 2 packs	<input type="checkbox"/> 3 packs	<input type="checkbox"/> N/A
From	(year) to (year)	<input type="checkbox"/> 1/2 pack	<input type="checkbox"/> 1 pack	<input type="checkbox"/> 2 packs	<input type="checkbox"/> 3 packs	<input type="checkbox"/> N/A

3.2b. Currently do you smoke cigarettes?

- Yes
- No

If yes,

On average, how many packs of cigarettes do you smoke in a day?

- 1/2 pack
- 1 pack
- 2 packs
- 3 packs

## Smoking History

3.3. Did you live in the same household as someone else who smoked cigarettes regularly in the house ...

- Yes
- No

If yes, between what ages? (Please indicate all that apply)

- 0 and 5
- 6 and 10
- 11 and 20
- 21 and 40
- 41 and 60
- 61 and above
- Don't know

*(These options are linked to age/year of birth, and may not be available to be answered if it is not applicable to a specific age group.)*

***Section 4: Environmental History – Animal Exposure***

## Environmental History - Animal Exposure

4.1. As a child (age 2-12), did you have any pets/animals you cared for or handled at home?

- Yes
- No

If yes, what kinds of pets/animals were those? (Please indicate all that apply)

- Household pets (e.g., dogs, cats, rabbits, mice, gerbils, hamsters, guinea pigs, rodents, spiders, birds, snakes, reptiles)
- Farm animals (e.g., horses, cows, sheep, goats, chickens)
- Other; Please List: \_\_\_\_\_

4.2. Currently, do you have any pets/animals you care for or handle at home/work?

- Yes
- No

If yes, what kinds of pets/animals were those? (please indicate all that apply)

- Household pets (e.g., dogs, cats, rabbits, mice, gerbils, hamsters, guinea pigs, rodents, spiders, birds, snakes, reptiles)
- Farm animals (e.g., horses, cows, sheep, goats, chickens)
- Other; Please List: \_\_\_\_\_

**Environmental History - Animal Exposure**

4.3. Did you ever live on a farm -or have regular exposure to a farm?

- Yes
- No

If yes, between what ages? (Please indicate all that apply)

- 0 and 5
- 6 and 10
- 11 and 20
- 21 and 40
- 41 and 60
- 61 and above
- Don't know

*(Change: These options are linked to age/year of birth, and may not be available to be answered if it is not applicable to a specific age group.)*

4.4. What type of farm was this? (Please indicate all that apply)

- Animal
  - Dairy Cattle
  - Beef Cattle
  - Pig
  - Chicken/poultry
- Grain
- Don't know
- Other

If Other, please specify: \_\_\_\_\_

***Section 5: Medication History***

## Medication History

5.1. Have you ever taken Birth Control Pills for longer than 3 months?

- Yes
- No

If yes, between what ages? (Please indicate all that apply)

- 15 and 20
- 21 and 25
- 26 and 30
- 31 and 35
- 36 and 40
- 41 and 45
- 46 and 50
- 51 and 55
- 56 and 60
- 61 and above

*(Change: These options are linked to age/year of birth, and may not be available to be answered if it is not applicable to a specific age group.)*

## Medication History

5.2. During the past week, have you taken any medications not prescribed by a doctor (e.g. over the Counter)? (e.g. for fever, occasional headache, congestion, cough, allergy, stomach upset, indigestion, heartburn, body aches/pains/discomforts, skin problems)

- Yes
- No

If yes, please select from below the medication(s) you are currently taking:

- Dyspepsia:  Gaviscon
  - Maalox
  - Mylanta
  - Pepid AC
  - Zantac 75
  - Other: \_\_\_\_\_
  
- Constipation:  Chronulac
  - Colace
  - Dulcolax
  - Fleet enema
  - Glycerin supp
  - Metamucil
  - Milk of Magnesia
  - Prodiem
  - Senokot
  - Senokot – S
  - Other: \_\_\_\_\_
  
- Diarrhea  Imodium
  - Lomotil
  - Pepto-Bismol
  - Other: \_\_\_\_\_

Note: This page is a continuation of the previous page for the same screen in the questionnaire program.

- Pain, Discomfort, and/or fever
  - Acephen
  - Acetaminophen/Tylenol/ Anacin
  - Acetylsalicylic Acid/ASA/Aspirin/ /Ecotrin
  - Anacin
  - Endocet
  - Excedrin
  - FeverAll
  - Gelpirin
  - Genapap
  - Genebs
  - Goody's
  - Ibuprofen – Advil, Motrin
  - Liquiprin
  - Panadol
  - Percocet
  - Roxice
  - Supac
  - Tempra
  - Tylenol (any type)
  - Tylox
  - Vanquish
  - Wygesic
  - Other: \_\_\_\_\_
  
- Vitamin Supplements on a weekly basis greater than 3 times per week:
  - Multi-Vitamins
  - Vitamin A
  - Vitamin B
  - Vitamin C
  - Vitamin D

Note: This page is a continuation of the previous page for the same screen in the questionnaire program.

- Vitamin E
- Iron
- Calcium
- Fish oil supplements
- Probiotic supplements
- Other: \_\_\_\_\_

## Medication History

5.3. Have you ever taken aspirin at least twice per week regularly for longer than 3 months?

- Yes  No

If yes, between what ages?

- 15 and 20
- 21 and 25
- 26 and 30
- 31 and 35
- 36 and 40
- 41 and 45
- 46 and 50
- 51 and 55
- 56 and 60
- 61 and above

*(Change: These options are linked to age/year of birth, and may not be available to be answered if it is not applicable to a specific age group.)*

5.4. Have you ever used Arthritis drugs?

- Yes  No

If yes, between what ages?

- 15 and 20
- 21 and 25
- 26 and 30
- 31 and 35
- 36 and 40
- 41 and 45
- 46 and 50
- 51 and 55
- 56 and 60
- 61 and above

*(Change: These options are linked to age/year of birth, and may not be available to be answered if it is not applicable to a specific age group.)*

## Medication History

5.5. Have you ever been told you have Crohn's Disease?

- Yes
- No

If yes, what medications have you ever used for Crohn's Disease treatment?

	Used In the Past	Use Currently
5-ASA (Also called Mesalamine):		
Asacol	<input type="checkbox"/>	<input type="checkbox"/>
†Mesasal	<input type="checkbox"/>	<input type="checkbox"/>
†Olsalazine Sodium (Dipentum)	<input type="checkbox"/>	<input type="checkbox"/>
†Pentasa	<input type="checkbox"/>	<input type="checkbox"/>
†Salofalk	<input type="checkbox"/>	<input type="checkbox"/>
†Salofalk enema	<input type="checkbox"/>	<input type="checkbox"/>
†Sulfasalazine (Azulfidine)	<input type="checkbox"/>	<input type="checkbox"/>
†Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Antibiotics:		
†Ciprofloxacin (Cipro)	<input type="checkbox"/>	<input type="checkbox"/>
Metronidazole (Flagyl)	<input type="checkbox"/>	<input type="checkbox"/>
†Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Corticosteroids:		
Budesonide (Entocort)		
†Entocort Capsules	<input type="checkbox"/>	<input type="checkbox"/>
Entocort Enema	<input type="checkbox"/>	<input type="checkbox"/>
Cortenema	<input type="checkbox"/>	<input type="checkbox"/>
†Methylprednisolone (Medrol)	<input type="checkbox"/>	<input type="checkbox"/>
†Prednisone	<input type="checkbox"/>	<input type="checkbox"/>

Other: \_\_\_\_\_

Immuno-modulators:

6-MP (Purinethanol)

†Azathioprine (Imuran)

Cyclosporine (Neoral)

†Methotrexate (Rheumatrex, Trexall)

†Mycophenolate Mofetil (Cellcept)

†Tacrolimus (Prograf)

†Other: \_\_\_\_\_

Biologics: †Adalimumab (Humira)

†Certolizumab (Cimzia)

Infliximab (Remicade)

†Other: \_\_\_\_\_

Other than all of above. Please specify: \_\_\_\_\_

N/A; I have NOT taken any medications for my Crohn's Disease treatment.

5.6. Have you ever been told you have Colitis?

- Yes
- No

If yes, what medications have you ever used for Colitis treatment?

	Used In the Past	Use Currently
5-ASA (Also called Mesalamine):		
Asacol	<input type="checkbox"/>	<input type="checkbox"/>
†Mesasal	<input type="checkbox"/>	<input type="checkbox"/>
†Olsalazine Sodium (Dipentum)	<input type="checkbox"/>	<input type="checkbox"/>
†Pentasa	<input type="checkbox"/>	<input type="checkbox"/>
†Salofalk	<input type="checkbox"/>	<input type="checkbox"/>
†Salofalk enema	<input type="checkbox"/>	<input type="checkbox"/>
†Sulfasalazine (Azulfidine)	<input type="checkbox"/>	<input type="checkbox"/>
†Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Antibiotics:		
†Ciprofloxacin (Cipro)	<input type="checkbox"/>	<input type="checkbox"/>
Metronidazole (Flagyl)	<input type="checkbox"/>	<input type="checkbox"/>
†Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Corticosteroids:		
Budesonide (Entocort)		
†Entocort Capsules	<input type="checkbox"/>	<input type="checkbox"/>
Entocort Enema	<input type="checkbox"/>	<input type="checkbox"/>
Cortenema	<input type="checkbox"/>	<input type="checkbox"/>
†Methylprednisolone (Medrol)	<input type="checkbox"/>	<input type="checkbox"/>
†Prednisone	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
Immuno-modulators:		
6-MP (Purinethanol)	<input type="checkbox"/>	<input type="checkbox"/>

Note: This page is a continuation of the previous page for the same screen in the questionnaire program.

- |                          |   |                          |                          |
|--------------------------|---|--------------------------|--------------------------|
|                          | †Azathioprine (Imuran)  | <input type="checkbox"/> | <input type="checkbox"/> |
|                          | Cyclosporine (Neoral)   | <input type="checkbox"/> | <input type="checkbox"/> |
|                          | †Methotrexate (Rheumatrex, Trexall)                             | <input type="checkbox"/> | <input type="checkbox"/> |
|                          | †Mycophenolate Mofetil (Cellcept)                               | <input type="checkbox"/> | <input type="checkbox"/> |
|                          | †Tacrolimus (Prograf)   | <input type="checkbox"/> | <input type="checkbox"/> |
|                          | †Other: _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| Biologics:               | †Adalimumab (Humira)  | <input type="checkbox"/> | <input type="checkbox"/> |
|                          | †Certolizumab (Cimzia)  | <input type="checkbox"/> | <input type="checkbox"/> |
|                          | Infliximab (Remicade)   | <input type="checkbox"/> | <input type="checkbox"/> |
|                          | †Other: _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | Other than all of above. Please specify: _____                  | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | N/A; I have NOT taken any medications for my Colitis treatment. |                          |                          |

## Medication History

5.7. Have you ever been told that you have Liver Disease?

- Yes
- No

If yes, what medications have you used for Liver Disease Treatment?

Interferon	Used In the Past	Use Currently
alpha 2a (Roferon-A)	<input type="checkbox"/>	<input type="checkbox"/>
alpha 2b (Intron)	<input type="checkbox"/>	<input type="checkbox"/>
beta 1a (Avonex, Rebif)	<input type="checkbox"/>	<input type="checkbox"/>
beta 1b (Bataseron)	<input type="checkbox"/>	<input type="checkbox"/>
†Interferon and ribavirin		
Interferon alfa 2a + Ribavirin (Roferon A + Ribavirin)	<input type="checkbox"/>	<input type="checkbox"/>
Interferon alfa 2b + Ribavirin (Intron A + Rebetol)	<input type="checkbox"/>	<input type="checkbox"/>
Pegylated interferon		
alfa 2a (Pegasys)	<input type="checkbox"/>	<input type="checkbox"/>
alfa 2b (PEG-Intron)	<input type="checkbox"/>	<input type="checkbox"/>
Pegylated interferon and ribavirin		
Peginterferon alfa 2a + Ribavirin (Pegasys and Copegus)	<input type="checkbox"/>	<input type="checkbox"/>
Peginterferon alfa 2b + Ribavirin (PEG-Intron and Rebetol)	<input type="checkbox"/>	<input type="checkbox"/>
Tacrolimus (Prograf)	<input type="checkbox"/>	<input type="checkbox"/>
Cyclosporine (Neoral)	<input type="checkbox"/>	<input type="checkbox"/>
Sirolimus (Rapamune) †	<input type="checkbox"/>	<input type="checkbox"/>
†Mycophenolate Mofetil (Cellcept)	<input type="checkbox"/>	<input type="checkbox"/>

- |  |                                     |                          |
|--|-------------------------------------|--------------------------|
| ↓Lamivudine (Heptovir, 3TC)  | <input type="checkbox"/>            | <input type="checkbox"/> |
| ↑Adefovir (Hepsera)  | <input type="checkbox"/>            | <input type="checkbox"/> |
| ↑Tenofovir (Viread)  | <input type="checkbox"/>            | <input type="checkbox"/> |
| Baraclude (Entecavir )   | <input checked="" type="checkbox"/> | <input type="checkbox"/> |
| ↑Tyzeka (Telbivudine)  | <input type="checkbox"/>            | <input type="checkbox"/> |
| ↑Ursodiol (Urso)   | <input type="checkbox"/>            | <input type="checkbox"/> |
| ↑Darbopoetin (Aranesp, Amgen)  | <input type="checkbox"/>            | <input type="checkbox"/> |
| <br>G-CSF/Granulocyte Colony-Stimulating Factors                                     |                                     |                          |
| lenograstim (Granocyte)  | <input type="checkbox"/>            | <input type="checkbox"/> |
| Filgrastim (Neupogen)  | <input type="checkbox"/>            | <input type="checkbox"/> |
| Pegylated Filgrastim (Neulasta)  | <input type="checkbox"/>            | <input type="checkbox"/> |
| <br>   |                                     |                          |
| <input type="checkbox"/> Other than above. Please specify: _____                     | <input type="checkbox"/>            | <input type="checkbox"/> |
| <br>   |                                     |                          |
| <input type="checkbox"/> N/A; I have NOT taken any medications for my liver disease. |                                     |                          |

***Section 6: Blood Product Exposure***

## **Blood product Exposure**

6.1. Have you ever had any of the following risk factors for blood exposure? (Please indicate all that apply)

- Blood or blood product transfusion
- Recreational drug usage (injection or nasal)
- Tattoo
- Body piercing (including ears, nasal, etc.)
- Close contact with Hepatitis patients including sharing toothbrushes and/or razors, kissing, and/or, sexual contact
- Other: \_\_\_\_\_
- None

***Section 7: Diet***

## **Diet**

7.1. Were you breast-fed as an infant?

- Yes
- No
- Don't know

7.2. As a child (ages 2-12), did you also regularly ingest water from non-tap sources at recreation locations (e.g. on vacations, camping, sport facilities, etc.)?

- Yes
- No
- Don't know

7.3. Currently, do you also regularly ingest water from non-tap sources at recreation locations (e.g. on vacations, camping, sport facilities, etc.)?

- Yes
- No
- Don't know

## Diet

7.4. As a child (ages 2-12), how often did you drink unpasteurized cow's milk?

- Never
- Less than once a month
- At least once a month
- At least once a week
- At least once a Day
- Don't know

7.5. Currently, how often do you normally drink unpasteurized cow's milk?

- Never
- Less than once a month
- At least once a month
- At least once a week
- At least once a Day
- Don't know

## Diet

7.6. As a child (ages 2-12), how often did you normally consume unpasteurized dairy product\*?

- Never
- Less than once a month
- At least once a month
- At least once a week
- At least once a Day
- Don't know

7.7. Currently, how often do you normally consume unpasteurized dairy product\*?

- Never
- Less than once a month
- At least once a month
- At least once a week
- At least once a Day
- Don't know

(\* click for definition)

## Diet

7.8. As a child (ages 2-12), how often did you normally have high sugar food (baked goods, candy, chocolate) or drinks (pop, iced capuccino, iced tea, lemonade, fruit juices, fruit cocktail drinks)?

- Never
- Less than once a month
- At least once a month
- At least once a week
- At least once a Day
- Don't know

7.9. Currently, how often do you normally have high sugar foods (baked goods, candy, chocolate) or drinks (pop, iced cappucino, iced tea, lemonade, fruit juices, cocktail drinks - with or without alcohol)?

- Never
- Less than once a month
- At least once a month
- At least once a week
- At least once a Day
- Don't know

## Diet

7.10. As a child (ages 2-12), how often did you normally eat "high fiber" foods? For example: bran, oats, vegetables (e.g. peas, broccoli, beans), fruits, nuts, or fiber supplements (e.g. Metamucil)?

- Never
- Less than once a month
- At least once a month
- At least once a week
- At least once a Day
- Don't know

7.11. Currently, how often do you normally eat "high fiber" foods? For example: bran, oats, vegetables (e.g. peas, broccoli, beans), fruits, nuts, or fiber supplements (e.g. Metatmucil)?

- Never
- Less than once a month
- At least once a month
- At least once a week
- At least once a Day
- Don't know

## Diet

7.12. As a child (ages 2-12), how often did you normally eat fish, seafood or fish oil (omega-3 and/or cod liver oil) supplements?

- Never
- Less than once a month
- At least once a month
- At least once a week
- At least once a Day
- Don't know

7.13. Currently, how often do you normally eat fish, seafood or fish oil (omega-3 and/or cod liver oil) supplements?

- Never
- Less than once a month
- At least once a month
- At least once a week
- At least once a Day
- Don't know

All questions have been completed. Thank you for participating in our questionnaire.