FRED HUTCHINSON
CANCER RESEARCH CENTER
A LIFE OF SCIENCE

ID NUMBER: ______________
To be assigned by study

THE BROCCOLI SPROUT STUDY

Initial Questionnaire

Please note: your participation is voluntary and any information you give us will be kept confidential. Your answers to this questionnaire will determine if you are eligible to participate in the study. Thank you for your time and interest.

You need to be: Older than 20 years of age and younger than 40 years of age.

There are some every day habits and medical treatments that could affect this research. Therefore, you cannot participate if:

- You take any prescription medications (this includes women taking birth-control pills or shots).
- You are currently pregnant or breastfeeding.
- You use tobacco now or any time within the past year (smoking and chewing tobacco).
- You use any type of recreational drug now or any time within the past year
- You drink *2 or more cans of beer OR 2 or more glasses of wine OR 3 or more ounces of hard liquor* every day.
- Your Body Mass Index (BMI) is over 30 (see table at the end of this questionnaire to help you figure out if your BMI is over 30.)

Again… if any of the above are true for you, please do not return this questionnaire.

Otherwise, please complete the following questionnaire.

NAME: ______________ (*First*) ________ (*MI*) ____________________ (*Last*)

MAILING ADDRESS: ____

City: ______________________________ State: WA Zip: ____________

TELEPHONE: __ __ __ - __ __ __ - __ __ __ __ (*Daytime*) __ __ __ - __ __ __ - __ __ __ __ (*Evening*)

MAY WE CONTACT YOU AT YOUR DAY PHONE? ☐ YES ☐ NO

MAY WE CONTACT YOU BY E-MAIL? ☐ NO
☐ YES:
e-mail address, please print clearly : ______________________________

ID NUMBER: ____________
To be assigned by study

For the following questions, please check the appropriate box or enter the information requested

1. Date of Birth: ☐☐-☐☐-19☐☐
Month Day Year

2. Gender: ☐ Male ☐ Female

3. Height: ____________ feet/inches

4. Weight: ____________pounds

5. Have you gained or lost more than 10 pounds in the last two months?

☐ No ☐ Yes

6. Are you on any type of special diet?

☐ No ☐ Yes

If yes, please indicate below the type of diet you are on:

- ☐ Vegetarian
- ☐ Gluten Free
- ☐ Macrobiotic
- ☐ Weight Reduction
- ☐ Weight Gain
- ☐ Low fat or cholesterol lowering
- ☐ Other:____________________

7. Do you have any food allergies or food intolerances?

☐ No ☐ Yes

If yes, please list the food(s):

8. Are there any foods that you strongly dislike and will not eat?

☐ No ☐ Yes

If yes, please list the food(s) you strongly dislike:

9. Do you take any dietary supplements including: multi-vitamins, individual vitamin/mineral supplements, protein powders, herbal extracts, teas/infusions?

☐ No ☐ Yes

If yes, would you be willing to not take them or any other dietary supplement for the duration of the study? This would begin one week before and continue through each study period?

☐ No ☐ Yes

10. Are you allergic to any medications?

☐ No ☐ Yes

Which?

____

____

11. At any time during the past three months, have you taken any type of prescription medication on a regular basis, ***including birth control (pill, shot, patch or IUD with hormones?*** (i.e., longer than 2 days at a time)

☐ No ☐ Yes

If yes, please list the medications you took, when and how often:

12. Have you taken antibiotics in the past 3 months?

☐ No ☐ Yes

13. Do you use any medication that you can buy without a prescription on a regular basis?

☐ No ☐ Yes

Which medications do you take:

Name of medication | Days per week

______________________ ______

______________________ ______

14. During the study, would you be willing to avoid taking pills or capsules that can be purchased without a prescription (e.g., Tylenol)?

☐ No ☐ Yes

15. Do you use any type of laxative or enema more than once a month (like Dulcolax, Fleetlax, Milk of Magnesia etc.) ?

☐ No ☐ Yes

16. Has a doctor ever told you that you had any of the following?

Please check each one:

	No	**YES**
Hypertension or high blood pressure	☐	☐
Peptic ulcer disease (ulcers of stomach or duodenum) or bleeding ulcers	☐	☐
Diabetes	☐	☐
Kidney disease, problems with kidney function	☐	☐
Liver disease, elevated liver enzymes, chronic hepatitis, or Hepatitis C	☐	☐
Chronic bowel diseases, such as Ulcerative Colitis, Crohn's Disease	☐	☐
Epilepsy or seizures	☐	☐

17. Do you smoke now, or have you smoked in the past year? (cigarettes, cigars, pipes, etc)

☐ No ☐ Yes

18. Do you live with anyone who smokes?

☐ No ☐ Yes

19. Do you drink 2 or more cans of beer OR 2 or more glasses of wine OR 3 or more ounces of hard liquor every day or most days?

☐ No ☐ Yes

20. In the last year, have you had frequent or unusual periods of constipation?

☐ No ☐ Yes

If yes, have you consulted a doctor/health professional or been prescribed medication?

☐ No ☐ Yes

21. Are you currently being treated for any disease or medical problems?

☐ No ☐ Yes

If yes, please list what disease or medical problem(s) you are being treated for and when they were diagnosed.

Disease/Medical Problem	Date Of Diagnosis
_______________	__________
_______________	__________

22. In the past four weeks, have you done any of the following activities?

Please check each one:

ACTIVITY	No	YES
Print making or silk screening	☐	☐
Oil or acrylic painting	☐	☐
Ceramics or pottery	☐	☐
Used a product to kill fleas or ticks on a pet	☐	☐

23. In the past four weeks, have you been exposed to any of the following.

Please check each one:

	No	YES
Paint Fumes	☐	☐
Smoke Fumes	☐	☐
Chemicals used to develop or process photographic film	☐	☐
Dyes	☐	☐
Grease or oils, such as cutting oil or creosote	☐	☐
Solvents, which are chemicals that dissolve grease, oil, paints or other materials, or that lubricate or soften	☐	☐
Chemicals to make rubber or plastic	☐	☐
Pesticides to control animal or plant pests	☐	☐
Chemical fertilizers	☐	☐
Dry cleaning fumes	☐	☐
Hairstyling chemicals (including dyes, bleaches, perms, relaxers)	☐	☐
Manicure chemicals	☐	☐
Paints or paint products, or paint thinner or remover (including interior, exterior house and deck paint, furniture and floor paint)	☐	☐
Stains, varnish, or other wood finishes	☐	☐

24. Please list any jobs you currently hold**.** (This will help us determine your exposure to certain types of chemicals that may influence metabolizing enzyme activity):

____

____

25. May we contact you about other studies related to genetics and their influence on metabolism?

☐ No ☐ Yes

*************** Women Only *******************

26. Women Only: Are you currently pregnant or planning on becoming pregnant in the next year?

☐ No ☐ Yes

27. Women Only: Are you currently breastfeeding?

☐ No ☐ Yes

28. Women Only: Do you use any medications specifically to prevent pregnancy? This includes pills (oral contraceptives), capsules, patches, shots or injections (e.g. DepoProvera), implants (e.g. Norplant) and IUD that release hormones (e.g. Mirena)

☐ No ☐ Yes

Thank you for completing this questionnaire.
Please send it back in the envelope provided or to:

Lisa Levy - The Broccoli Sprout Study
FHCRC - 1100 Fairview Ave. N.
M4-B402
Seattle, WA 98109-1024

We will contact you soon - Thank you again.

BMI Table - to see if you are eligible based on BMI (Body Mass Index): find your height in the left-hand column labeled Your Height. Move across to the weight (in pounds). If you weigh more than the weight stated on that line you are not eligible for this study (your BMI is higher than 30).

Your Height		Your Weight (in pounds)
feet	**inches**	**You are not eligible if you weigh more than:**
4	**10**	143
	11	148
5	**0**	153
	1	158
	2	164
	3	169
	4	174
	5	180
	6	186

Your Height		Your Weight (in pounds)
feet	**inches**	**You are not eligible if you weigh more than:**
5	**7**	191
	8	197
	9	203
	10	209
	11	215
6	**0**	221
	1	227
	2	233
	3	240
	4	246