

**March 20, 2002**

**DISTANT SIBS QUESTIONNAIRE  
(BY PHONE)**

**SUBJECT IDENTIFICATION**

FIRST NAME: \_\_\_\_\_

LAST NAME: \_\_\_\_\_

MAIDEN NAME : \_\_\_\_\_ (for women,  
write both last and maiden name)

BIRTHDATE :                   |\_|\_|/|\_|\_|/|\_|\_|\_|\_|

PLACE OF BIRTH \_\_\_\_\_ PV |\_|\_|

GENDER :           1.   |\_| M           2.   |\_| F

SUBJECT CODE IGC-|\_|\_|-|\_|\_|\_|\_|

RELATIONSHIP   1. Brother of \_\_\_\_\_

2. Sister of \_\_\_\_\_

3. Half-brother of \_\_\_\_\_

4. Half-sister of \_\_\_\_\_

PHONE NUMBER       |\_|\_|\_|\_|/|\_|\_|\_|\_|\_|\_|\_|\_|\_|\_|

INTERVIEW DATE :   |\_|\_|/|\_|\_|/|\_|\_|\_|\_|

STARTING TIME:       |\_|\_| : |\_|\_|

INTERVIEW INTERRUPTED   at PAGE. |\_|\_|

HOUR : |\_|\_| |\_|\_|

RESTARTED |\_|\_|/|\_|\_|/|\_|\_|\_|\_| (date)

RESTARTING TIME |\_|\_| : |\_|\_| (hour)

INTERVIEWER INITIALS, FIRST & LAST NAMES :       |\_|\_|

INTERVIEWER CODE:                                   |\_|\_|

## SECTION A. SUBJECT'S CHARACTERISTICS

A1. What's the highest level of schooling that you've completed?

### Educational Level

1.  None
2.  Elementary School
3.  Lower Middle School
4.  Teacher Training High School
5.  Technical, Industrial, Commercial H. School
6.  College Prep. High Schools (Classical, Science, Art)
7.  Post H.S. Academies or Junior Colleges
8.  Degree
9.  Other \_\_\_\_\_

A2. At the moment, are you: (check all that apply):

1.  Married and/or cohabiting
2.  Separated
3.  Widowed
4.  Divorced
5.  Single

A3. How tall are you? Centimeters

A4. One year ago, what was your weight? Kilograms

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Note

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## SECTION B. TOBACCO SMOKING

*Now I would like to ask you some specific questions about types and amounts of tobacco consumption during your life*

**Fill in each row of the table**

B1. In your entire life have you smoked at least		B2. At what age did you start?	B3 How long did you smoke regularly?	B4 During the last year you smoked , what was the average number of cigarettes (cigarillos, cigars, pipe) you smoked?
a. 100 cigarettes?	<input type="checkbox"/> 1. YES (B2) <input type="checkbox"/> 0 NO (B1b)	<input type="text"/>	<input type="text"/> or <input type="text"/> months                  years	<input type="text"/> / day (B1b) <input type="text"/> / week (B1b) <input type="text"/> / month (B1b)
b. 50 cigarillos?	<input type="checkbox"/> 1. YES (B2) <input type="checkbox"/> 0 NO (B1b)	<input type="text"/>	<input type="text"/> or <input type="text"/> months                  years	<input type="text"/> / day (B1c) <input type="text"/> / week (B1c) <input type="text"/> / month (B1c)
c. 35 cigars?	<input type="checkbox"/> 1. YES (B2) <input type="checkbox"/> 0 NO (B1b)	<input type="text"/>	<input type="text"/> or <input type="text"/> months                  years	<input type="text"/> / day (B1d) <input type="text"/> / week (B1d) <input type="text"/> / month (B1d)
d. 35 pipes of tobacco?	<input type="checkbox"/> 1. YES (B2) <input type="checkbox"/> 0 NO (B1b)	<input type="text"/>	<input type="text"/> or <input type="text"/> months                  years	<input type="text"/> / day <input type="text"/> / week <input type="text"/> / month

**If YES in B1a go to SECTION C (Fagerstrom Index), p. 4**

**If YES in B1 b or c or d, go to SECTION D (Nicotine dependency), p. 5**

**If NO in all of B1 (a, b, c, and d), go to SECTION E (Occupational History), p. 7**

For EVER cigarette smokers (current and former) if B1a=YES)  
**SECTION C. FAGERSTROM INDEX**  
(If you are a former smoker, refer to the period in which you smoked most)

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C1. How soon after you wake up do/did you smoke your first cigarette?

- |    |                          |                |
|----|--------------------------|----------------|
| 1. | <input type="checkbox"/> | ≤ 5 minutes    |
| 2. | <input type="checkbox"/> | 6-30 minutes   |
| 3. | <input type="checkbox"/> | 31- 60 minutes |
| 4. | <input type="checkbox"/> | > 60 minutes   |

C2. Do/did you find it difficult to refrain from smoking in places where it is forbidden , e.g. in church, at the library, in the theater, etc.?

- |    |                          |     |    |                          |    |
|----|--------------------------|-----|----|--------------------------|----|
| 1. | <input type="checkbox"/> | Yes | 0. | <input type="checkbox"/> | No |
|----|--------------------------|-----|----|--------------------------|----|

C3. Which cigarette (of the day) would you hate most to give/gave up?

- |    |                          |                               |
|----|--------------------------|-------------------------------|
| 0. | <input type="checkbox"/> | The first one in the morning? |
| 1. | <input type="checkbox"/> | Any other?                    |

C4. How many cigarettes a day do/did you smoke ?

- |    |                          |         |
|----|--------------------------|---------|
| 0. | <input type="checkbox"/> | ≤ 10    |
| 1. | <input type="checkbox"/> | 11 – 20 |
| 2. | <input type="checkbox"/> | 21 – 30 |
| 3. | <input type="checkbox"/> | ≥ 31    |

C5. Do/did you smoke more frequently during the first hours after awakening than during the rest of the day?

- |    |                          |     |    |                          |    |
|----|--------------------------|-----|----|--------------------------|----|
| 1. | <input type="checkbox"/> | Yes | 0. | <input type="checkbox"/> | No |
|----|--------------------------|-----|----|--------------------------|----|

C6. Do/did you smoke if you are so ill that you are in bed most of the day?

- |    |                          |     |    |                          |  |
|----|--------------------------|-----|----|--------------------------|--|
| 1. | <input type="checkbox"/> | Yes | 0. | <input type="checkbox"/> |  |
|----|--------------------------|-----|----|--------------------------|--|

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**check B1,**

**if YES in B1b or c or d, go to section D (Nicotine dependency) on the next page**

(only for ever smokers, i.e. YES in B1 a or b or c or d)

## SECTION D. NICOTINE DEPENDENCY, QUITTING HISTORY

If current smoker

D0. Did it ever happen that you tried to quit smoking but were unsuccessful?

1. Yes (D1)

0. No (skip this section)

If former smoker or D0.=YES

D1. *I'm going to ask you about some problems that you might have had when you stopped smoking or smoked less tobacco than usual. Think about the time when you had the most problems when you went without cigarettes or had less than usual. During that time...*

	0.NO 1.YES	If Yes, How long?	Occur together
a. were you more irritable, angry or frustrated than usual?	<input type="checkbox"/>	1. <input type="text"/> <input type="text"/> <input type="text"/> days 2. <input type="text"/> <input type="text"/> <input type="text"/> weeks 3. <input type="text"/> <input type="text"/> <input type="text"/> months	<input type="checkbox"/> 1. Yes <input type="checkbox"/> 0 No/ don't Know
b. ...were you more nervous or anxious than usual?	<input type="checkbox"/>	1. <input type="text"/> <input type="text"/> <input type="text"/> days 2. <input type="text"/> <input type="text"/> <input type="text"/> weeks 3. <input type="text"/> <input type="text"/> <input type="text"/> months	as above
c. ...were you more restless than usual?	<input type="checkbox"/>	1. <input type="text"/> <input type="text"/> <input type="text"/> days 2. <input type="text"/> <input type="text"/> <input type="text"/> weeks 3. <input type="text"/> <input type="text"/> <input type="text"/> months	
d. ...did you have more trouble concentrating than usual?	<input type="checkbox"/>	1. <input type="text"/> <input type="text"/> <input type="text"/> days 2. <input type="text"/> <input type="text"/> <input type="text"/> weeks 3. <input type="text"/> <input type="text"/> <input type="text"/> months	
e. ...did your heart slow down ?	<input type="checkbox"/>	1. <input type="text"/> <input type="text"/> <input type="text"/> days 2. <input type="text"/> <input type="text"/> <input type="text"/> weeks 3. <input type="text"/> <input type="text"/> <input type="text"/> months	
f. ...did you feel more down or depressed than usual?	<input type="checkbox"/>	1. <input type="text"/> <input type="text"/> <input type="text"/> days 2. <input type="text"/> <input type="text"/> <input type="text"/> weeks 3. <input type="text"/> <input type="text"/> <input type="text"/> months	
g. ...did your appetite increase or did you gain weight ?	<input type="checkbox"/>	1. <input type="text"/> <input type="text"/> <input type="text"/> days 2. <input type="text"/> <input type="text"/> <input type="text"/> weeks 3. <input type="text"/> <input type="text"/> <input type="text"/> months	
h. ...did you have more trouble sleeping than usual?	<input type="checkbox"/>	1. <input type="text"/> <input type="text"/> <input type="text"/> days 2. <input type="text"/> <input type="text"/> <input type="text"/> weeks 3. <input type="text"/> <input type="text"/> <input type="text"/> months	

*If in D1 has all **NO** answers, go to section E  
If a,b,c are **YES** answers, skip to question D5.  
If there are **four or more YES** answers in D1 ask D2*

D2. Did at least four of these "symptom categories" occur together in the first 24 hours after you stopped or cut down?

1.  YES

0.  NO (D5)

*If iD2 is **YES**, return to top of question D1 to ask:*

*Which ones? (Code in **Occur Together** column)*

**Occur Together Only**

D3. How old were you the first time these problems occurred together after quitting?

Ons Age

D4. How old were you the last time these problems occurred together after quitting?

Rec Age

D5. Did the problems you had after quitting or cutting down on smoking ever interfere with your work, school, or household responsibilities?

1.  YES

0.  NO

D6. Did you start smoking again or use other sources of nicotine to avoid having the problems that quitting might cause?

1.  YES

0.  NO

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## SECTION E. OCCUPATIONAL HISTORY

*Now, I'm going to ask you some basic information about the kinds of work you have done in your life*

C1 Can you tell me the jobs that you have held longest (up to 3)?

JOB 1	In what kind of industry?	In which year did he/she start?	In which year did he/her finish?
..... ..... ..... ..... ISCO  _ _ _ _ _	..... ..... ..... ..... ..... ISIC  _ _ _ _ _	_ _ _ _	_ _ _ _
..... ..... ..... ..... ISCO  _ _ _ _ _	..... ..... ..... ..... ..... ISIC  _ _ _ _ _	_ _ _ _	_ _ _ _
..... ..... ..... ..... ISCO  _ _ _ _ _	..... ..... ..... ..... ..... ISIC  _ _ _ _ _	_ _ _ _	_ _ _ _

**SECTION F. FAMILY MEDICAL HISTORY**

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*Now I'd like to ask you some questions about your family's health. I'm going to ask information only for your blood relatives ( i.e. father, mother, brothers, sisters and children if not acquired, and not for your wife/husband )*

F1. Was any of your relatives ever diagnosed with malignant tumors?

- 1.  YES
- 0.  NO
- 9.  DONT'KNOW

If YES,

1) relationship \_\_\_\_\_ 1) Tumor site..... ICD\_CODE |\_|\_|\_|\_|  
 Age at first diagnosis|\_|\_| or Year |\_|\_|\_|\_|  
 2) Tumor site..... ICD\_CODE |\_|\_|\_|\_|  
 Age at first diagnosis|\_|\_| or Year |\_|\_|\_|\_|  
 3) Tumor site..... ICD\_CODE |\_|\_|\_|\_|  
 Age at first diagnosis|\_|\_| or Year |\_|\_|\_|\_|

Did he/she ever smoke at least 100 cigarettes (or 50 cigarillos or 35 cigars/pipes) in his/her life?

- 1.  YES
- 0.  NO

2) relationship \_\_\_\_\_ 1) Tumor site..... ICD\_CODE |\_|\_|\_|\_|  
 Age at first diagnosis|\_|\_| or Year |\_|\_|\_|\_|  
 2) Tumor site..... ICD\_CODE |\_|\_|\_|\_|  
 Age at first diagnosis|\_|\_| or Year |\_|\_|\_|\_|  
 3) Tumor site..... ICD\_CODE |\_|\_|\_|\_|  
 Age at first diagnosis|\_|\_| or Year |\_|\_|\_|\_|

Did he/she ever smoke at least 100 cigarettes (or 50 cigarillos or 35 cigars/pipes) in his/her life?

- 1.  YES
- 0.  NO

3) relationship \_\_\_\_\_ 1) Tumor site..... ICD\_CODE |\_|\_|\_|\_|  
 Age at first diagnosis|\_|\_| or Year |\_|\_|\_|\_|  
 2) Tumor site..... ICD\_CODE |\_|\_|\_|\_|  
 Age at first diagnosis|\_|\_| or Year |\_|\_|\_|\_|  
 3) Tumor site..... ICD\_CODE |\_|\_|\_|\_|  
 Age at first diagnosis|\_|\_| or Year |\_|\_|\_|\_|

Did he/she ever smoke at least 100 cigarettes (or 50 cigarillos or 35 cigars/pipes) in his/her life?

1.  YES

0.  NO



## SECTION M. DEPRESSION (CES\_D-5 questions)

I am going to ask you some questions about how you've been feeling during the past week. You can choose how often you've felt this way during the past week .

Don't think too much about the things I read you. We want your first reaction. There are no right or wrong answers.

M1. Did you feel depressed?

1.  Not at all or less than 1 day last week
2.  One to two days last week
3.  Three to four days last week
4.  Five to seven days last week

M2. Did you feel hopeful about the future?

1.  Not at all or less than 1 day last week
2.  One to two days last week
3.  Three to four days last week
4.  Five to seven days last week

M3. Were you happy?

1.  Not at all or less than 1 day last week
2.  One to two days last week
3.  Three to four days last week
4.  Five to seven days last week

M4. Did you feel sad?

1.  Not at all or less than 1 day last week
2.  One to two days last week
3.  Three to four days last week
4.  Five to seven days last week

M5. You couldn't get going?

1.  Not at all or less than 1 day last week
2.  One to two days last week
3.  Three to four days last week
4.  Five to seven days last week

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Thank you for your participation

ENDING TIME OF INTERVIEW|\_|\_|/|\_|\_|

NOTE \_\_\_\_\_

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