

COHORT I QUESTIONNAIRE

NAME:

SEX:

ADDRESS:

TELEPHONE NUMBER:

YELLOW FORM – GENERAL MEDICAL BACKGROUND QUESTIONS

Please answer the following questions concerning your past medical history and present health status.

1. Have you ever been diagnosed with any of the following diseases? Please circle all that apply.

	None
Diabetes, stroke, hypertension, myocardial infarction/angina pectoris, asthma, chronic bronchitis, allergy, kidney disease, cystitis, chronic hepatitis/liver cirrhosis, peptic gastric/duodenal ulcer, biliary stone, others (_____) cancer (stomach, lung, colorectum, liver, breast, uterine, others: _____)	

2. Have your parents/immediate family had any of the following diseases?

	Father	Mother	Brothers	Sisters	Spouse
(Example) Diabetes	○				
Diabetes					
Stroke					
Hypertension					
Myocardial infarction/angina pectoris					
Chronic hepatitis/liver cirrhosis					
Gastric/duodenal ulcer					
Cancer					
(site)	()	()	()	()	()

3. Have you ever received a blood transfusion?

0. No	1. Yes
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4. Are you currently taking any medications prescribed by your physician?

No	Yes
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If yes, please check any of the following drugs you are currently taking

Drugs for hypertension, drugs for decreasing the blood cholesterol level, drugs for diabetes, drugs for gout, others (please specify _____)
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5. How often do you take vitamin supplements?

0. Seldom	1. 1-4 days per week	2. Almost every day
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If 1 or 2, please check which kinds of vitamins you take.

Vitamin B compound, Vitamin C, Vitamin E, Vitamin A, Multi-vitamin, others (_____)

6. Have you undergone a medical examination or screening test within the past year?

No	Yes
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If yes, please check any of the following you have undergone.

Blood pressure, blood test, electrocardiogram, funduscopy, chest X-ray, sputum examination, gastric X-ray, gastric endoscopy, occult blood test, colon x-ray, colonoscopy

7. What are your height and body weight?

Height

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 cm Weight

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 kg

8. Has your body weight changed more than 5 kg since you were 20 years old?

1. Decreased	2. Not changed	3. Increased
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9. How often do you participate in sports or physical exercise?

0. Almost never	1. 1-3 days a month	2. 1-2 days a week	3. 3-4 days a week	5. Almost every day
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PURPLE FORM – SMOKING AND DRINKING QUESTIONS

Please answer the following questions concerning smoking and alcohol drinking.

1. Have you ever been a smoker?'

0. No	1. Yes
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If yes, how old were you when you began smoking?

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years old



Do you currently smoke cigarettes?

0. No	1. Yes	2. Occasionally
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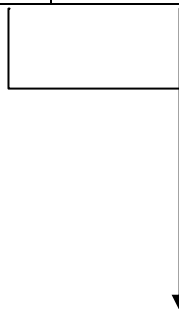
If you no longer smoke,
how old were you when
you quit smoking?



If yes, how many cigarettes a day do you smoke?

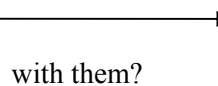
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Cigarette
s /day



2. Have you ever lived with a smoker for more than 10 years?

0. No	Yes
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If yes, how old were you when you were living with them?

1. Younger than 20 years old	2. Older than 20 years old	3. Both
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3. How often are you exposed to passive smoking (more than 1 hour /day) outside the home, such as at work?

0. Almost never	1. 1-3 days a month	2. 1-4 days a week	3. Almost every day
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4. How often do you drink alcoholic beverages such as Japanese sake, shochu, awamori, beer, whisky, brandy, or wine?

0. Almost never	1. 1-3 days a month	2. 1-2 days a week	3. 3-4 days a week	4. 5-6 days a week	5. Every-day
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*For beer, please convert medium bottles (500 ml) to 0.8 bottle and small bottles (350 ml) to 0.6 bottle.

If you drink more than 1-2 days a week, how much do you drink, on average, every day?

Japanese sake	_____ go (180ml)
Shochu, awamori	_____ go (180ml)
*Beer (large 633ml)	_____ bottles
Whisky (30ml)	_____ cups
Others	_____ ml

Do you smoke more cigarettes than usual while drinking alcohol?

0. Do not smoke	1. Smoke as usual	2. More than usual
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5. Do you blush soon after drinking alcohol?

1. Yes	2. Probably yes	3. No change	4. Don't know
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6. Does your heart beat faster than usual or do you get a headache soon after drinking alcohol?

1. Yes	2. Probably yes	3. No change	4. Don't know
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GREEN FORM – BASELINE DIETARY QUESTIONS

Please answer the following questions concerning your usual food intake.

- How many days per week do you eat the following meals? Indicate the frequency with a circle.

	Seldom	1-2 days/week	3-4 days/week	Almost every day
Breakfast (not just coffee or juice)	0	1	2	3
Dinner at home	0	1	2	3
Between-meal snacks	0	1	2	3

- On average, how many bowls (normal size) of rice do you eat per day?

0. Less than one per day	1. Approximately _____ bowls a day
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3. How often do you drink miso soup? (Check one)

0. Almost never	1. 1-2 days/week	2. 3-4 days/week	3. Almost daily
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If almost daily, how many bowls on average do you drink per day?

_____Bowls/day

4. Circle your food preferences/dislikes.

Preferences/Dislikes	Like very much	Like a little	Dislike
Food rich in oil	1	2	3
Spicy foods	1	2	3
Very salty foods	1	2	3
Sour food	1	2	3
Sweets, such as desserts	1	2	3
Hot foods and drinks	1	2	3

5. Circle the way you most commonly prepare the foods you eat most.

	Raw	Boil	Grill	Deep-fry	Stir-fry	Other
Meats	1	2	3	4	5	6
Fish and shellfish	1	2	3	4	5	6
Vegetables	1	2	3	4	5	6

6. How often do you have fried foods such as stir-fry or deep-fry?

0. Almost never	1. 1-2 days/week	2. 3-4 days/week	3. Almost daily
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7. Do you avoid the burned/charred parts of fish or meat?

0. No	1. Yes
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8. Circle the frequency with which you eat (or do not eat) each of the following foods:

Frequency	Almost never	1-2 days /week	3-4 days /week	Almost daily
Noodles (not instant)	0	1	2	3
Breads (including Japanese confection breads, sandwiches)	0	1	2	3
Butter or margarine	0	1	2	3
Fruits	0	1	2	3
Green vegetables (spinach, garland, chrysanthemum leaves, etc.)	0	1	2	3
Yellow vegetables (carrots, pumpkin, squash, etc.)	0	1	2	3
Other vegetables (Chinese cabbage, radish, tomato, cucumber, etc.)	0	1	2	3
Dressings and mayonnaise	0	1	2	3
Pickles (salty or salty rice-bran paste)	0	1	2	3
Mushrooms	0	1	2	3
Potatoes (sweet potatoes, potatoes, etc.)	0	1	2	3
Seaweeds (wakame, nori, kombu, etc.)	0	1	2	3
Soybean and soybean products (tofu, deep-fried tofu, fermented soybeans, etc.)	0	1	2	3
Other legumes (broad beans, etc.)	0	1	2	3
Eggs	0	1	2	3
Milk and dairy products (except cheeses)	0	1	2	3
Cheese	0	1	2	3
Beef	0	1	2	3
Pork	0	1	2	3
Chicken	0	1	2	3
Bacon, ham, sausage	0	1	2	3
Liver	0	1	2	3
Fresh fish and shellfish	0	1	2	3
Dried fish (mezashi, etc.) and salted fish (salted salmon, etc.)	0	1	2	3
Salted roe (cod or salmon roe, etc.)	0	1	2	3
Salted fish guts and salted sea urchin	0	1	2	3

9. Are you careful about your salt intake?

0. No	1. Yes
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10. Are you careful about your cholesterol intake?

0. No	1. Yes
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2. Do you eat many green and yellow vegetables?

0. No	1. Yes
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3. Are you careful about your fat intake?

1. No	2. Yes
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4. Compared to average, how would you describe the volume of food you typically eat in a meal?

1. Much less	2. Less	3. Same	4. More	5. Much more
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5. How would you describe your usual meals?

1. Eat until half-full	2. Eat until 80% full	3. Eat until full
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6. Circle the frequency of your average consumption of each of the following beverages:

Frequency	Almost never	1-2 days/ week	3-4 days/ week	Almost daily		
				Cups/glasses/cans/bottles		
				1-2/day	3-4/day	≥5/day
Japanese tea (green tea)	0	1	2	3	4	5
Chinese tea (oolong tea)	0	1	2	3	4	5
Black tea	0	1	2	3	4	5
Other teas	0	1	2	3	4	5
Coffee	0	1	2	3	4	5
Milk	0	1	2	3	4	5
Cola, carbonated soft drinks	0	1	2	3	4	5
100% fruit juice	0	1	2	3	4	5
Vegetable juice	0	1	2	3	4	5

7. How many teaspoons of sugar do you use per cup of coffee or black tea?

(If you do not take sugar, please indicate "0")

		teaspoons
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BLUE FORM – PERSONAL BACKGROUND QUESTIONS

Please answer the following questions concerning your personal life.

1. What is your date of birth?

Showa (Japanese calendar) (year) (month) (day)

2. Where were you born?

Prefecture City, town or village

3. Where did you reside for the longest period before you were 20 years old?

Prefecture City, town or village

4. How many years have you lived at your present address?

*Please include the time you were at this address even if at years
another address for part of the year.

5. Is your place of residence within 1 km (walking distance within 15 min) of the coastline?

0. No	1. Yes
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6. What is your current job?

If you have more than one job at the same time, or change jobs according to season, please check all that apply.

(Example) Office work at town office. Agriculture (spring-autumn) and control a ski lift (winter)

For how many years have you held this job?

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 years

7. Have you ever had occupational exposure to the following materials? If yes, please check any of the following materials you have been exposed to.

	No
Solvents, dust, lead, undesired noise, vibration, high voltage, ionizing radiation, foul odors, pesticides	
Other (please specify _____)	
Other (please specify _____)	

8. At present, with whom do you live? Circle all that apply.

Spouse	Children	Parents	Others	Living alone
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9. How many siblings and children do you have? Do not include yourself.

	Brothers		Sisters		Children												
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10. What is your educational background?

1. Junior high school	2. High school	3. Junior college, vocational school	4. University or higher	5. Other
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11. In spring and autumn, how often do you take a bath or shower?

0. Almost never	1. 1-2 times a week	2. 3-4 times a week	3. Almost every day
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How often do you soak in a bath tub?

0. Almost never	1. 1-2 times a week	2. 3-4 times a week	3. Almost every day
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12. What is the temperature of the water in which you usually bathe?

0. Tepid	1. Average	2. Hot
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13. How would you describe your own personality?

Please choose the most appropriate description from each category.

1. Hasty and impatient	2. Average	3. Calm and peaceful
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1. Quick tempered	2. Average	3. Mild
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1. Active	2. Average	3. Passive
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1. Eager to excel in everything	2. Average	3. Carefree and at ease about everything
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1. Fastidious and fussy	2. Average	3. Rough and ready, easygoing
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14. How many hours do you usually sleep?

0. No	1. Yes
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15. Are your bowel movements regular every day?

<input type="text"/>	<input type="text"/>	Hours
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16. How much stress do you have in your daily life?

1. A little	2. Average	3. A lot
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17. Do you enjoy your life?

1. No	2. Average	3. Yes
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PINK FORM – FEMALE -SPECIFIC QUESTIONS

Women, please answer the following questions.

1. How old were you when you first started menstruating? years old

2. Do you still menstruate?

1. Yes	2. Natural menopause	3. Artificial menopause
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If you are no longer menstruate, how old were you when menopause began?

3. Is/was your menstrual cycle regular? years old

(before menopause, if applicable)

0. No	1. Yes
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How long is your average menstrual cycle length? Days

4. Have you ever taken female hormone drugs?

0. No	Yes
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If yes, are you currently taking hormones?

1. No	2. Yes
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5. In total, how many pregnancies have you had? times

At what age was your first pregnancy? years old

6. In total, how many deliveries have you had (including stillbirths) times

At what age was your first delivery? years old

Did you breastfeed your children?

0. No	1. Yes
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7. Have you ever been told by a doctor that you have had any of the following diseases?

Check all that apply.	No
Mastopathy, mastitis, mammary gland tumor, uterine fibroids, endometritis, ovarian cyst, others (_____)	

8. Have you undergone any of the following screening tests within the past year?

Cervical cancer

0. No	1. Yes
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 Breast cancer

0. No	1. Yes
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This is the end of the survey. Thank you very much for taking the time to fill out this questionnaire. Please take a moment to fill in any questions you may have skipped.

Date:

Heisei (Japanese calendar) (year) (month) (day)

Who provided the above information?

1. Myself	2. Representative (please specify)
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Finally, if you have any questions, please write them in the box below.