Dear Participant:

Your continued support of the NLST is greatly appreciated.

To simplify your ongoing participation, we have significantly shortened your bi-annual follow-up form. The health care provider questions on this form relate only to the diagnosis and/or treatment of lung cancers and the diagnosis of other cancers. Please answer all of the questions to the best of your knowledge. The information you give us should be for the time period from:

[1] to TODAY

SITE-SPECIFIC CONTACT INFO

Please note the following when completing this form:

- The form should only take about 5-10 minutes to complete.
- Please complete the form with blue or black ink.
- Sign, date and return in the stamped, addressed envelope (enclosed).
- Call us if you have questions about the form, we would love to hear from you.

Thank-you for your participation in the NLST!

NLST Staff Only: Follow-up Time Period

- [ ] 6 mo
- [ ] 1 Y
- [ ] 1.5 Y
- [ ] 2 Y
- [ ] 2.5 Y
- [ ] 3 Y
- [ ] 3.5 Y
- [ ] 4 Y
- [ ] 4.5 Y
- [ ] 5 Y
- [ ] 5.5 Y
- [ ] 6 Y
- [ ] 6.5 Y
- [ ] 7 Y
- [ ] 7.5 Y
- [ ] 8 Y

"Copyright 2008"
### Part A: Lung Cancer Diagnosis and Treatment

1. Since the date on the front of this form, have you received a diagnosis or treatment of lung cancer by any health care provider? [3]
   - ☐ 1 No (If no, skip to Part B)
   - ☐ 2 Yes (If yes, please complete the rest of the page)
   - ☐ 3 I'm not sure (Skip question 2, but do list any providers seen during this time period in the boxes below)


Please provide the names and contact information for providers/hospitals that were associated with the diagnosis and/or treatment of lung cancer.

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<tr>
<th>I.</th>
<th>Name of provider:</th>
<th>Provider Type:</th>
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3. Were any other providers/hospitals involved in your diagnosis and/or treatment of lung cancer? [16]
   - ☐ 1 No
   - ☐ 2 Yes
Part B: **Other Cancer Diagnosis**

1. Since the date on the front of this form, have you been diagnosed with any other type of cancer by a health care provider?  
   
   \[17\]  
   *Do not list diagnoses of squamous cell skin cancer or basal cell skin cancers. (If you are unsure of the type of skin cancer, please include it here.)*  
   
   - [ ] 1 No (If no, skip to Part C)  
   - [ ] 2 Yes (If yes, please complete the rest of the page)  
   - [ ] 3 I'm not sure (Skip questions 2 and 3, but do list any providers seen during this time period in the boxes below)  

2. Please record the date of diagnosis of this other type of cancer \[18\] - \[19\] - \[20\] (mm-dd-yyyy)  

3. Please specify the site or type of this other cancer: \[21\]  

Please provide the name and contact information for the providers/hospitals that were associated with the diagnosis of the cancer you recorded above. You do not need to provide the names of providers or clinics where you may have been treated for this cancer.

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4. Were any other providers/hospitals involved in your diagnosis of the cancer recorded above?  
   
   - [ ] 1 No  
   - [ ] 2 Yes
Part C: Cigarette Smoking Questions

1. Do you now smoke cigarettes (one or more cigarettes per week)?
   - 1 No (If no, skip to Part D)
   - 2 Yes

2. How many cigarettes do you usually smoke per day, on average?
   - 1 Fewer than 1 per day
   - 2 ____________ per day (enter a whole number)

3. In the past six (6) months, how many times have you intentionally quit smoking cigarettes (not even a puff) for at least 24 hours?
   - 1 I did not intentionally try to quit smoking
   - 2 I intentionally quit smoking ____________ times for at least 24 hours (enter a whole number)

Part D: Conclusion

1. What is your present insurance status: (check only one)
   - 0 Other
   - 1 Private Insurance
   - 2 Medicare
   - 3 Medicare and Private Insurance
   - 4 Medicaid
   - 5 Medicare and Medicaid
   - 6 Military or Veterans Administration
   - 7 Self Pay
   - 8 No Means of Payment
   - 9 Unknown/Decline to answer

2. Who completed this form
   - 1 Participant
   - 2 Participant with assistance from other person (complete D2a below)
   - 3 Family member or friend (participant unable to provide the information)

   2a. Specify the person who assisted you (check all that apply)
   - ACRIN-NLST Staff member
   - Family member
   - Other, specify
   - Unknown

Please provide your signature and write the date that you completed this form.

______________________________  _______ - _____ - 20 (mm-dd-yyyy)
Your Signature (participant or proxy)  Date you completed this form

Thank-you for your time and effort in providing this information.
Your cooperation is very important to the success of the NLST!