ACRIN 6664
Participant Questionnaire
for CT Colonography

Instructions to Participant: Please complete all items and return the questionnaire to the Research Associate. A copy will be given to you upon request. This information is necessary for __________________. Answer each question by placing a (✓) in the box next to the appropriate question.

Participant’s Signature: ____________________________

Date Questionnaire Completed: ___-___-____ (mm/dd/yyyy)

Medical History

1. Do you have a history of:
   a. Lung cancer or nodule? ☐ No ☐ Yes ☐ Uncertain
   b. Kidney cancer or cyst? ☐ No ☐ Yes ☐ Uncertain
   c. Kidney Stones? ☐ No ☐ Yes ☐ Uncertain
   d. Abdominal Aortic Aneurysm? ☐ No ☐ Yes ☐ Uncertain
   e. Liver disease? Cirrhosis? ☐ No ☐ Yes ☐ Uncertain
   f. Hemia? ☐ No ☐ Yes ☐ Uncertain
   g. Gallbladder disease? ☐ No ☐ Yes ☐ Uncertain
   h. Cyst or cancer of the ovary? ☐ No ☐ Yes ☐ Uncertain

2. Please list any other medical problems:
   1. __________________________________________
   2. __________________________________________
   3. __________________________________________
   4. __________________________________________
   5. __________________________________________

COMMENTS: ______________________________________

_________________________________________________

_________________________________________________

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Name of person responsible for data 1 ______-____-____ Date form completed

Name of person entering data into web 2