

Date completed:

_____/_____/_____
(month) (day) (year)

BETTER Health Survey™ Comprehensive

Name: _____

Thank you for completing the BETTER Health Survey™!

Your answers will help us provide better care for you.

During the visit, you and your healthcare provider will talk about how you can improve your health and the screening tests recommended for you. You will be able to set your own health goals and create a plan to help you achieve them.

Later, your healthcare provider will check with you to review your progress, help you change your plan, if needed, and set new goals.

INSTRUCTIONS: Please answer all questions as best you can.

For each question, please circle the number that matches your answer or fill in the blank as needed.

Your answers will help your healthcare provider get ready for your Prevention visit.

You are free to refuse to answer any question you wish.

If you wish to make a comment on any of the questions, please use the space at the end of the survey.

Please complete your survey and return it to your healthcare provider.



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SECTION A: GENERAL INFORMATION

Instructions: These questions are for both men and women.

For each of the following questions, please circle the number that matches your response or fill in the blank as appropriate.

1. **What sex were you assigned at birth?** Your sex at birth helps us to know what kinds of screening tests you may need. (Circle one number)

1. Male
 2. Female
 3. Decline to answer

2. **What pronouns do you prefer?** For example, he, she, they, etc. (Write your preferred pronouns in the space below)

3. **What is your date of birth?** (Write your month and year of birth in the space below)

e.g.
 (month) (year)
 Feb 1959

4. **How tall are you without shoes on?** (Write your height in feet and inches or centimetres in the space below)

_____ (feet) _____ (inches) **OR** _____ (cm)

5. **How much do you weigh?** (Write your weight in pounds or kilograms in the space below)

_____ (pounds) **OR** _____ (kg)

BMI Calculator

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SECTION B: CHRONIC HEALTH CONDITIONS

Instructions: *These questions are for both men and women.*

The next questions ask about some health conditions that you may have that were diagnosed by a healthcare professional.

For each of the following questions, please circle the number that matches your response.

6. Have you ever been told by a healthcare professional that you had any of the following health conditions?

6a. Diabetes? *Diabetes is a chronic disease, where the body either can't produce insulin or cannot properly use the insulin it produces. Insulin is a hormone that controls the amount of sugar in the blood. (Circle one number)*

- 1. Yes
- 2. No → **go to question 6c**
- 3. Don't know → **go to question 6c**

6b. What type of diabetes were you diagnosed with? (Circle one number)

- 1. Type 1 (formerly juvenile diabetes, usually diagnosed at a young age and is only treated with insulin)
- 2. Type 2 (formerly non-insulin dependent diabetes, can be treated with pills or insulin)
- 3. Don't know

6c. A stroke? *A stroke occurs when the blood supply to part of your brain is interrupted or severely reduced, depriving brain tissue of oxygen and nutrients. (Circle one number)*

- 1. Yes
- 2. No
- 3. Don't know



6d. Angina, a heart attack, congestive heart failure (CHF), coronary artery disease (CAD), or peripheral vascular disease (PVD)? *Angina* refers to chest pain, including a squeezing, suffocating, or burning feeling. *A heart attack* is when blood flow is blocked from a section of the heart, not allowing oxygen to get in. *Congestive heart failure* is a condition that develops after the heart becomes damaged or weakened, limiting the movement of blood. *Coronary artery disease* is a type of heart disease that happens when arteries in the heart are blocked. *Peripheral vascular disease* is a narrowing of the peripheral arteries serving the legs, stomach, arms, and head. (Circle one number)

- 1. Yes
- 2. No
- 3. Don't know

6e. Hypertension or high blood pressure? *High blood pressure, also called hypertension, means there is too much pressure in your blood vessels.* (Circle one number)

- 1. Yes
- 2. No
- 3. Don't know

6f. Chronic kidney disease or chronic renal failure? *Chronic kidney disease or chronic renal failure describes a gradual loss of kidney function over time.* (Circle one number)

- 1. Yes
- 2. No
- 3. Don't know

6g. Hyperlipidemia or high cholesterol, or high lipid (fat) levels, such as cholesterol, in the blood? (Circle one number)

- 1. Yes
- 2. No
- 3. Don't know

6h. A genetic condition for cholesterol or familial hypercholesterolemia? (Circle one number)

- 1. Yes
- 2. No
- 3. Don't know



7. **Are you currently being treated for osteoporosis?** *Osteoporosis causes bones to become weak and brittle, putting you at greater risk for sudden and unexpected bone fractures. Treatment for osteoporosis can include medication or focusing on changing risk factors for bone loss and falls.* (Circle one number)

- 1. Yes → go to Section C
- 2. No
- 3. Don't know

8. **Have you ever been told by a healthcare provider that you have had a fragility fracture?** *A fragility fracture is a fracture that results from a minor injury that would not normally result in a fracture, such as a fall from standing height or less.* (Circle one number)

- 1. Yes
- 2. No
- 3. Don't know

SECTION C: CANCER SCREENING FOR MEN AND WOMEN

Instructions: These questions are for both men and women.

For each of the following questions, please circle the number that matches your response.

9. **Have you ever been told by a healthcare professional that you had any of the following health conditions?**

9a. **Lung cancer?** *Lung cancer is a type of cancer that begins in the lungs, usually in the cells that line the air passages.* (Circle one number)

- 1. Yes
- 2. No
- 3. Don't know

9b. **Colorectal (bowel) cancer?** *Colorectal cancer is a type of cancer that develops in the colon and/or the rectum.* (Circle one number)

- 1. Yes → go to Section D (page 7)
- 2. No
- 3. Don't know

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9c. Crohn's disease? *Crohn's disease is a condition in which the gastrointestinal tract is inflamed over a long period of time. (Circle one number)*

- 1. Yes
- 2. No
- 3. Don't know

9d. Ulcerative Colitis? *Ulcerative colitis is a chronic inflammation of the colon that produces ulcers in its lining. (Circle one number)*

- 1. Yes
- 2. No
- 3. Don't know

9e. Familial Adenomatous Polyposis (FAP)? *FAP is an inherited condition in which many polyps form on the inside walls of the colon and rectum. (Circle one number)*

- 1. Yes
- 2. No
- 3. Don't know

9f. Hereditary Nonpolyposis Colon Cancer (HNPCC) or Lynch syndrome? *HNPCC or Lynch Syndrome is an inherited disorder. (Circle one number)*

- 1. Yes
- 2. No
- 3. Don't know

10. Have any of your close relatives (parents, siblings, children) tested positive for a genetic mutation related to Lynch syndrome? *Lynch Syndrome is an inherited disorder. (Circle one number)*

- 1. Yes
- 2. No
- 3. Don't know



11. **Have you had genetic testing for a mutation related to Lynch syndrome?**
(Circle one number)

- 1. Yes
- 2. No → *go to Section D*
- 3. Don't know → *go to Section D*

12. **Did you test positive for a genetic mutation related to Lynch syndrome?**
(Circle one number)

- 1. Yes
- 2. No
- 3. Don't know

SECTION D: SCREENING TESTS AND CHRONIC HEALTH CONDITIONS FOR WOMEN

Instructions: These questions are for women. If you are male, please go to Section E (page 11).

For each of the following questions, please circle the number that corresponds to your response or fill in the blank as appropriate.

13. **Are you post-menopausal? That is, have you not had your period for at least 1 year?** (Circle one number)

- 1. Yes
- 2. No
- 3. Don't know

14. **Have you ever been told by a healthcare professional that you had any of the following health conditions?**

14a. **Gestational diabetes. That is, diabetes during pregnancy?** (Circle one number)

- 1. Yes
- 2. No
- 3. Don't know

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14b. Immunocompromised? *Being immunocompromised means having a weakened immune system* (Circle one number)

- 1. Yes
- 2. No → go to question 14d
- 3. Don't know → go to question 14d

14c. Please tell us the reason(s) that you have been told you are immunocompromised from the list below. (Circle all that apply)

- 1. You are an organ transplant recipient.
- 2. You have chronic use of corticosteroids. *Corticosteroids are used to provide relief for inflamed areas of the body. Chronic use means that you have used the medication for at least a month.*
- 3. You have been prescribed an alkylating agent, antimetabolite, and/or tumour necrosis factor (TNF) blocker. *An alkylating agent is a type of medication that is used in the treatment of cancer. Antimetabolites are medications used to treat certain diseases associated with abnormally rapid cell growth. A TNF blocker is a medication that helps stop inflammation from conditions such as arthritis.*
- 4. Other (Please specify): _____
- 5. Don't know

14d. Cervical intraepithelial neoplasia (CIN) 2 or 3? *Cervical intraepithelial neoplasia (CIN) is a condition in which abnormal cells grow on the surface of your cervix. With early detection and treatment, you can prevent these abnormal cells from becoming cancerous. CIN is classified on a scale from one to three.* (Circle one number)

- 1. Yes
- 2. No
- 3. Don't know

15. Have you ever had:

15a. A hysterectomy. That is, your womb/uterus removed? (Circle one number)

- 1. Yes
- 2. No → go to question 16
- 3. Don't know → go to question 16

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15b. Did they remove your cervix (“total hysterectomy”) at the time of the hysterectomy? (Circle one number)

- 1. Yes
- 2. No
- 3. Don't know

16. Have you ever been told by a healthcare professional that you had cervical cancer? *Cervical cancer is a type of cancer that forms in tissues of the cervix (the organ connecting the uterus and vagina).* (Circle one number)

- 1. Yes → go to question 19
- 2. No
- 3. Don't know

17. Have you had a Pap test in the past 3 years? *A Pap test is done to test for cervical cancer or other conditions, like infections of inflammation. It involves putting a speculum into the vagina and using a small brush or spatula to gently remove cells from the cervix to be checked under a microscope.* (Circle one number)

- 1. Yes
- 2. No → go to question 19
- 3. Don't know → go to question 19

18. Were any of the Pap tests results abnormal? *An abnormal pap test result means that the test found some cells on your cervix that do not look normal. Having an abnormal pap test does not mean that you have cancer.* (Circle one number)

- 1. Yes
- 2. No
- 3. Don't know

19. Have you ever been told by a healthcare professional that you had any of the following health conditions?

19a. Ovarian cancer? *Ovarian cancer is a type of cancer that forms in tissues of the ovary.* (Circle one number)

- 1. Yes
- 2. No
- 3. Don't know



19b. Polycystic ovarian disease or polycystic ovary syndrome? *Polycystic ovarian disease is a hormonal disorder in which a woman's hormones are out of balance.* (Circle one number)

- 1. Yes
- 2. No
- 3. Don't know

19c. Breast cancer? *Breast cancer is a type of cancer that forms in tissues of the breast.* (Circle one number)

- 1. Yes → **go to Section F (page 12)**
- 2. No
- 3. Don't know

20. Have you ever had a bilateral mastectomy? That is, have you had both of your breasts surgically removed? (Circle one number)

- 1. Yes → **go to Section F (page 12)**
- 2. No
- 3. Don't know

21. Have any of your close relatives (parents, siblings, children) tested positive for a mutation in the BRCA1 or BRCA2 genes? *BRCA1 and BRCA2 are genes that normally help to stop cell growth.* (Circle one number)

- 1. Yes
- 2. No
- 3. Don't know

22. Have any of your other relatives (aunts, uncles, cousins, grandparents) tested positive for a mutation in the BRCA1 or BRCA2 genes? (Circle one number)

- 1. Yes
- 2. No
- 3. Don't know



23. **Have you had genetic testing for a mutation in the BRCA1 or BRCA2 genes?**
(Circle one number)

- 1. Yes
- 2. No → go to Section F (page 12)
- 3. Don't know → go to Section F (page 12)

24. **Did you test positive for a BRCA1 or BRCA2 gene mutation?** (Circle one number)

- 1. Yes
- 2. No
- 3. Don't know

SECTION E: CANCER SCREENING FOR MEN

Instructions: These questions are for men. If you are female, please go to Section F (page 12).

For each of the following questions, please circle the number that corresponds to your response.

25. **Have you ever been told by a healthcare professional that you had prostate cancer?** Prostate cancer is a type of cancer that forms in tissues of the prostate.
(Circle one number)

- 1. Yes → go to next section
- 2. No

26. **Have you ever had a prostate-specific antigen (PSA) test?** Prostate-specific antigen, or PSA, is a protein produced by cells of the prostate gland. The PSA test measures the level of PSA in a man's blood. (Circle one number)

- 1. Yes
- 2. No



SECTION F: LIFESTYLE AND NUTRITION

Instructions: These questions are for both men and women.

The next group of questions ask about some of your lifestyle behaviours such as smoking, physical activity, eating habits and alcohol intake.

For each question, please circle the number that matches your response or fill in the blank as appropriate.

27. Do you currently smoke cigarettes every day, some days, or not at all? (Circle one number)

1. Every day
 2. Some days
 3. Not at all → go to question 32

28. On average, how many cigarettes do you currently smoke each day? (Write the number in the space below)

Number of cigarettes smoked daily: _____

29. How long have you smoked cigarettes? (Write the length of time in the space below)

_____ years + _____ months.

Pack Years Calculator

30. Please indicate how prepared you are to decrease the number of cigarettes you currently smoke. Where 0 = not prepared to decrease and 10 = already decreasing. (Circle one number)

How prepared

0 1 2 3 4 5 6 7 8 9 10

Not prepared to decrease Already decreasing

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31. **How confident are you that you can decrease the number of cigarettes you currently smoke?** Where 0 = not at all confident and 10 = extremely confident. (Circle one number)

How confident

0 1 2 3 4 5 6 7 8 9 10

Not at all confident Extremely confident

→ go to question 36

32. **Have you ever smoked cigarettes regularly, that is, at least one cigarette per day?** (Circle one number)

1. Yes
 2. No → go to question 36

33. **On average, how many cigarettes did you smoke each day when you were smoking?** (Write the number in the space below)

Number of cigarettes smoked daily: _____

34. **How long did you smoke cigarettes?** (Write the length of time in the space below)

_____ years + _____ months

35. **How long ago did you stop smoking cigarettes completely?** (Write the length of time in the space below)

_____ years + _____ months

36. **In the past 12 months, how often have you used tobacco by way of vaporizers (or vape) or e-cigarettes?** (Circle one number)

1. Every day or almost every day
 2. Weekly
 3. Monthly
 4. Every few months
 5. Not at all



37. In the past 12 months, how often have you used other tobacco products by way of snuff or chewing? (Circle one number)

- 1. Every day or almost every day
- 2. Weekly
- 3. Monthly
- 4. Every few months
- 5. Not at all

38. In the past 12 months, how often have you used non-medical or recreational marijuana or cannabis products by way of vaporized cannabis, cannabis oil, edible cannabis, or smoked cannabis? *Vaporized cannabis is cannabis oil or plant material that is heated using a vaporizer or vape to create vapor that is inhaled. Cannabis oil is an oil extract taken by mouth and includes THC and/or CBD capsules, sprays, or solutions. Edible cannabis is a product, substance or mixture that has cannabis in it and is meant to be consumed like food. Smoked cannabis is dried cannabis that is inhaled like a cigarette.* (Circle one number)

- 1. Every day or almost every day
- 2. Weekly
- 3. Monthly
- 4. Every few months
- 5. Not at all



39. Please tell us the type and amount of physical activity involved in your work.¹
(Circle one number)

- 1. I am not employed (for example: retired, retired for health reasons, unemployed, full-time carer, etc.).
- 2. I spend most of my time at work sitting (such as in an office).
- 3. I spend most of my time at work standing or walking. However, my work does not require much intense physical effort (for example: shop assistant, hairdresser, security guard, child care provider, etc.).
- 4. My work involves definite physical effort including handling of heavy objects and use of tools (for example: plumber, electrician, carpenter, cleaner, hospital nurse, gardener, postal delivery workers, etc.).
- 5. My work involves vigorous physical activity including handling of very heavy objects (for example: scaffolder, construction worker, refuse collector, etc.).

40. During the last week, please indicate with an “x” how many hours you spent on each of the following activities. Please answer the questions even if you are not employed.

	None	Some, but less than 1 hour	1 hour, but less than 3 hours	3 hours or more
a) Physical exercise such as swimming, jogging, aerobics, football, tennis, gym workout, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b) Cycling, including to work and during leisure time	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c) Walking, including walking to work, shopping, for pleasure, etc.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d) Housework/Childcare	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e) Gardening/Do-it-yourself projects	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

¹ Physical activity questions are the General Practice Physical Activity Questionnaire (GPPAQ). Heron N, Tully MA, McKinley MC, Cupples ME. Physical activity assessment in practice: a mixed methods study of GPPAQ use in primary care. BMC Family Practice. 2014; 15:11.



41. How would you describe your usual walking pace? (Circle one number)

- 1. Slow pace
- 2. Steady average pace
- 3. Brisk pace
- 4. Fast pace

42. Do you do muscle strengthening, body weight or resistive exercises 2 or more days per week? *Muscle strengthening, body weight and resistive exercises include using weight machines (typically at a gym, fitness, or community centre), push-ups, squats, sit ups, and using resistance bands or free weights, like dumbbells.* (Circle one number)

- 1. Yes
- 2. No

43. Please indicate how prepared you are to increase the amount of physical activity you currently do. Where 0 = not prepared to increase and 10 = already increasing. (Circle one number)

How prepared

0 1 2 3 4 5 6 7 8 9 10

Not prepared to increase Already increasing

44. How confident are you that you can increase the amount of physical activity you currently do? Where 0 = not at all confident and 10 = extremely confident. (Circle one number)

How confident

0 1 2 3 4 5 6 7 8 9 10

Not at all confident Extremely confident

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45. Please tell us about your eating habits²:

45a. Is olive oil the main source of fat for cooking? (Circle one number)

1. Yes
 2. No

45b. Do you have 4 tablespoons (60 ml) or more of olive oil each day? (Circle one number)

1. Yes
 2. No

45c. Do you eat 4 servings of vegetables each day? *1 serving is ½ cup raw or cooked vegetables or 1 cup of raw, leafy greens.* (Circle one number)

1. Yes
 2. No

45d. Do you have 3 or more servings fruit each day? *1 serving is a whole fruit or ½ cup of fruit.* (Circle one number)

1. Yes
 2. No

45e. Do you eat less than 2 servings of red meat or processed meats each day, including red meat, hamburger, or other meat products (for example ham, sausage, etc.)? *1 serving is 75 grams or 3 ounces.* (Circle one number)

1. Yes
 2. No

45f. Do you eat 1 tablespoon (15 ml) or less of butter, margarine or cream each day? (Circle one number)

1. Yes
 2. No

² Adapted from the Mediterranean Diet Score Tool + Adherence Screener. Dietitians of Canada. Mediterranean Diet Toolkit: Supporting Patients to Reduce CVD Risk and Improve Mental Health. March 2020.



45g. Do you drink less than 1 can (355 ml or 12 oz) of sugar sweetened beverages each day? (Circle one number)

- 1. Yes
- 2. No

45h. Do you have 3 or more servings of legumes (peas, beans, or lentils) each week? 1 serving is half a cup to two-thirds of a cup. (Circle one number)

- 1. Yes
- 2. No

45i. Do you have 4 or more servings of fish or seafood [or 6 or more servings of shellfish] each week? Shellfish are animals with a shell-like exterior such as shrimp, crayfish, crab, clams, lobster, scallops, oysters, and mussels. 1 fish or shellfish serving is 3.5-5 oz or 100-150 g. One seafood serving 4-5 pieces. (Circle one number)

- 1. Yes
- 2. No

45j. Do you eat commercial baked goods such as cookies, doughnuts or cake less than 2 times each week? (Circle one number)

- 1. Yes
- 2. No

45k. Do you eat nuts 3 or more times each week? 1 serving is 30 g or 1 ounce. (Circle one number)

- 1. Yes
- 2. No

45l. Do you choose chicken or turkey more often than beef, pork, hamburger, or sausage? (Circle one number)

- 1. Yes
- 2. No

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45m. Do you consume vegetables, pasta, or rice dishes with a homemade sauce of sautéed garlic, onions, olive oil and tomatoes 2 or more times a week? (Circle one number)

- 1. Yes
- 2. No

Mediterranean Diet Score

0

46. Please circle the number that shows how prepared you are to improve your current diet. Where 0 = not prepared to improve and 10 = already improving. (Circle one number)

How prepared

0 1 2 3 4 5 6 7 8 9 10

Not prepared
to improve

Already
improving

47. How confident are you that you could improve your current diet? Where 0 = not at all confident and 10 = extremely confident. (Circle one number)

How confident

0 1 2 3 4 5 6 7 8 9 10

Not at all
confident

Extremely
confident

48. During the past 12 months, have you had any drinks containing alcohol? (Circle one number)

- 1. Yes
- 2. No → go to Section G (page 21)

49. On average, how many drinks containing alcohol do you currently have each week? A drink is defined as a 341 ml (12 oz.) glass containing 5% alcohol (beer, cider or cooler), a 142 ml (5 oz.) glass of wine with 12% alcohol content, or a 43 ml (1.5 oz.) shot/serving of 40% distilled alcohol content (rye, gin, rum, etc.). (Write the number in the space below)

Number of drinks containing alcohol you have weekly: _____

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50. How many drinks containing alcohol do you have on a typical day when you are drinking? (Circle one number)

- 1. 1
- 2. 2
- 3. 3
- 4. 4
- 5. 5
- 6. 6
- 7. 7
- 8. 8
- 9. 9
- 10. 10 or more

51. **MEN:** How often do you have 4 or more drinks containing alcohol on one occasion? (Circle one number)

WOMEN: How often do you have 3 or more drinks containing alcohol on one occasion? (Circle one number)

- 1. Never
- 2. Less than monthly
- 3. Monthly
- 4. Weekly
- 5. Daily or almost daily

52. Please indicate how prepared you are to reduce the amount of alcohol you currently drink. Where 0 = not prepared to reduce and 10 = already reducing. (Circle one number)

How prepared

0 1 2 3 4 5 6 7 8 9 10

Not prepared to reduce Already reducing



53. How confident are you that you could reduce the amount of alcohol you currently drink? Where 0 = not at all confident and 10 = extremely confident. (Circle one number)

How confident

0 1 2 3 4 5 6 7 8 9 10

Not at all confident Extremely confident

SECTION G: GENERAL HEALTH

Instructions: These questions are for both men and women.

These next questions ask for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities.

Please circle the number that you think best describes how you feel. If you are unsure about how to answer a question, please give the best answer you can.

54. Over the LAST 2 WEEKS, how often have you been bothered by any of the following problems?³

54a. Little interest or pleasure in doing things (Circle one number)

- 1. Not at all
- 2. Several days
- 3. More than half the days
- 4. Nearly every day

54b. Feeling down, depressed, or hopeless (Circle one number)

- 1. Not at all
 - 2. Several days
 - 3. More than half the days
 - 4. Nearly every day
- PHQ-2 Score
0

³ The Patient Health Questionnaire – 2 (PHQ-2).

Kroenke K, Spitzer L, Williams JBW. The Patient Health Questionnaire – 2: Validity of a two-item depression screener. Medical Care. 2003; 41:11.

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SECTION H: FAMILY MEDICAL HISTORY

Instructions: These questions are for both men and women.

Knowing your family history can help your health care practitioners provide better care for you.

55. The 2 tables below list some chronic diseases. Please complete the 2 tables to the best of your knowledge.

*For each of the following, please only include relatives that are related to you by **blood or birth** and do not include relatives related to you by marriage.*

If one or more of your blood relatives has been diagnosed with the disease, please indicate the age of the relative who was diagnosed the youngest. For example, if your sister was diagnosed with diabetes at age 20 and your brother was also diagnosed with diabetes at age 35, you would write “20” under youngest age at diagnosis.

If you are not sure at what age someone was diagnosed, please use your best guess for the age.

Chronic Diseases	First Degree Relatives					
	Your Parents		Your Brothers or Sisters		Your Children	
	Number of parents with disease	Youngest age at diagnosis	Total number of brothers or sisters with disease	Youngest age at diagnosis	Total number of children with disease	Youngest age at diagnosis
Breast Cancer						
Colorectal (Bowel) Cancer						
Diabetes						
Osteoporosis						
Ovarian Cancer						
Pancreatic Cancer						
Prostate Cancer						

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	Second Degree Relatives <i>Uncles, Aunts, Nieces, Nephews, and Grandparents</i>			
Chronic Diseases	On Your Mother's Side		On Your Father's Side	
	Total number of relatives with disease	Youngest age at diagnosis	Total number of relatives with disease	Youngest age at diagnosis
Breast Cancer				
Colorectal (Bowel) Cancer				
Ovarian Cancer				
Pancreatic Cancer				
Prostate Cancer				

56. If you indicated that one or more of your first or second-degree relatives had breast cancer, were any of those relatives male? (Circle one number)

- 1. Yes
- 2. No
- 3. Don't know
- 4. Not applicable

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SECTION I: ABOUT YOU

Instructions: These questions are for both men and women.

For each of the following questions, please circle the number that corresponds to your response or fill in the blank as appropriate.

57. Your ethnic and cultural background helps determine your risk for cancer and other chronic diseases. Some groups are known to be at higher risk. The list below will help us determine if YOU are at higher risk for chronic diseases.

Please tell us if any of the following describe your ethnic or cultural background. (Circle all that apply)

- 1. Indigenous → go to question 57a.
- 2. African-Caribbean (e.g., African, African Canadian, Afro-Caribbean, etc.)
- 3. Ashkenazi Jewish
- 4. East Asian (e.g., Chinese, Japanese, Korean, Taiwanese, etc.)
- 5. European (e.g., British, French, German, Spanish, Swedish, etc., but not including Icelandic)
- 6. Icelandic
- 7. Latin American (e.g., Mexico, Central and South American countries)
- 8. Middle Eastern (e.g., Arab, Persian, etc.)
- 9. North American (e.g., American, Canadian)
- 10. Southeast Asian (e.g., Cambodia, Filipino, Indonesian, Malaysian, Thai, Vietnamese, etc.)
- 11. South Asian (e.g., Bangladeshi, East Indian, Pakistani, Sri Lankan, etc.)
- 12. West Asian (e.g., Afghan, Egyptian, Iranian, Kurdish, Lebanese, Turkish, etc.)
- 13. Don't know
- 14. Prefer not to answer

57a. **If you are an Indigenous person, do you identify as First Nations, Inuk/Inuit and/or Métis?** (Circle all that apply)

- 1. First Nations
- 2. Inuk or Inuit
- 3. Métis
- 4. Don't know
- 5. Prefer not to answer

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58. If there is anything else that you would like to comment on, or feel is important to include, please feel free to write in the space below.

THANK YOU for completing the BETTER Health Survey™!

Please return your survey to your healthcare provider.

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