

NEURO-ONCOLOGY CENTER
WDMCI AT FLORIDA HOSPITAL

DATABASE FORM 1- DEMOGRAPHICS

Information is for research purposes only and will not affect your medical treatment

Today's date_____

Patient name_____

Patient address_____

Home phone # ()____-_____

E-mail address_____

Date of birth (____/____/____)

Gender (circle one) Male Female

Ethnicity

American Indian/Alaskan
Asian/Pacific Islander
Black/African- American
Caucasian, not Hispanic
Hispanic/Latino, not Caucasian or Black
Middle Eastern/Arabic
Other

Family History

(please list relationship to anybody in
your family with a brain tumor)

Type	Family relation
#1_____	_____

#2_____	_____
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Educational Level

(check highest completed)
Grade/Middle School
High School
College/University
Graduate/Professional School

Exposure History

(please list any environmental factor that
you fear may have contributed to your
condition)

Household Income

(check range of your family's total
household income, in US\$)

\$0-15,000
\$15,001-30,000
\$30,001-45,000
\$>\$45,000

THANK YOU FOR COMPLETING THE QUESTIONNAIRE