



WOMEN

If this is not your full **LEGAL** name and mailing address, please make changes on this page.



Dear Cancer Prevention Study Participant,

Thank you for your continued commitment to cancer research!

Your time and willingness to continue updating your information regarding health outcomes, lifestyle, screening practices and use of medications and vitamins are critical to the fight against cancer. We hope you will, once again, take the time to carefully complete this survey and return it to us within 10 days.

Please verify that your full legal name and address printed above are correct, and make changes if needed. We may use this information to verify or identify study participants who have died and to collect data from death indexes on cause of death, including cancer. We may also collect data from cancer registries on diagnosis date and tumor characteristics such as site, type of tumor, and stage of disease. As always, this information is kept strictly confidential and is used for medical statistical purposes only.

Thank you again for your invaluable contribution to the Cancer Prevention Study. If you have any questions about the survey, please call us at 1-800-646-7853.

Sincerely,



Susan M. Gapstur, PhD, MPH
Vice President of Epidemiology

BEFORE TURNING TO THE QUESTIONNAIRE, PLEASE READ THE BOXES BELOW.

If the person whose name appears on this form **has died**, please mark this square and **STOP HERE**. Return the blank questionnaire in the postage-paid envelope.

The answers to the following questions should be provided by the person named above. If someone else provides the answers **about that person**, please mark this square.

START HERE

1. Is this your correct date of birth?

Yes →

No, my birthday is: / /

Month Day Year



THANK YOU FROM THE EPIDEMIOLOGY STAFF OF THE AMERICAN CANCER SOCIETY

INSTRUCTIONS

- Use a blue or black ink pen or dark pencil. Do not use felt tip markers or gel pens.
- Please answer the following questions by filling in the square or placing an X in the square.

↳ Correct: or

- **To change** an answer, fill in the square and **circle** the square of your preferred answer.

↳ Correct: or

- Please PRINT where applicable. Enter only one letter or number per box, and stay within the confines of the box.

C P S 2

- **Please make an effort to fill out every question. If unsure, estimate to your best ability.**

GENERAL HEALTH

2. In general, would you say your health is:

- | | |
|------------------------------------|-------------------------------|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Fair |
| <input type="checkbox"/> Very Good | <input type="checkbox"/> Poor |
| <input type="checkbox"/> Good | |

3. In general, would you say your quality of life is:

- | | |
|------------------------------------|-------------------------------|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Fair |
| <input type="checkbox"/> Very Good | <input type="checkbox"/> Poor |
| <input type="checkbox"/> Good | |

4. In general, how would you rate your physical health?

- | | |
|------------------------------------|-------------------------------|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Fair |
| <input type="checkbox"/> Very Good | <input type="checkbox"/> Poor |
| <input type="checkbox"/> Good | |

5. In general, how would you rate your mental health, including your mood and your ability to think?

- | | |
|------------------------------------|-------------------------------|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Fair |
| <input type="checkbox"/> Very Good | <input type="checkbox"/> Poor |
| <input type="checkbox"/> Good | |

6. In general, how would you rate your satisfaction with your social activities and relationships?

- | | |
|------------------------------------|-------------------------------|
| <input type="checkbox"/> Excellent | <input type="checkbox"/> Fair |
| <input type="checkbox"/> Very Good | <input type="checkbox"/> Poor |
| <input type="checkbox"/> Good | |

7. How would you rate your pain on average?

- 0 = No Pain
 1 2 3 4 5 6 7 8 9
 10 = Worst pain imaginable

8. How would you rate your fatigue on average?

- | | |
|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> None | <input type="checkbox"/> Severe |
| <input type="checkbox"/> Mild | <input type="checkbox"/> Very Severe |
| <input type="checkbox"/> Moderate | |

9. How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?

- | | |
|------------------------------------|---------------------------------|
| <input type="checkbox"/> Never | <input type="checkbox"/> Often |
| <input type="checkbox"/> Rarely | <input type="checkbox"/> Always |
| <input type="checkbox"/> Sometimes | |

13. Has a physician ever told you that you had any of the following conditions? (If **NO**, leave blank.)
 (If yes, mark the **yes** square and **year of diagnosis** for each illness you have had diagnosed.)

	Mark here for YES	Year first diagnosed		
		Before August 2009	August 2009- July 2011	After July 2011
Diabetes mellitus (except during pregnancy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial infarction (heart attack) or angina pectoris	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalized for MI \longrightarrow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronary bypass, angioplasty or stent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke (CVA) or TIA (Transient ischemic attack)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carotid surgery (Endarterectomy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's Disease	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ALS (Lou Gehrig's Disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema or chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wrist fracture, vertebral fracture or hip fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

GENERAL

14. What is your **current** marital status?

- Married
- Divorced
- Widowed
- Never Married
- Separated

15. What is your **current** living arrangement?

- Alone
- Assisted living
- With spouse or partner
- Nursing home
- With other family
- Other

16. What is your **current** work status?

- Retired
- Volunteer
- Work full-time
- Homemaker
- Work part-time
- Disabled

17. What is your **current** weight?

Pounds

18. Do you **currently** smoke cigarettes?

- No
- Yes

How many per day?

- 1-4 cigarettes
- 25-34
- 5-14
- 35-44
- 15-24
- 45 or more

MEDICATIONS

19. In the **past two years**, have you used any of these medications on a **regular** basis for osteoporosis or other reason?

- Alendronate (Fosamax) Calcitonin (Miacalcin, Fortical)
 Risedronate (Actonel, Atelvia) Didronel (etidronate)
 Boniva (ibandronate) Forteo injections (teriparatide)

20. Do you **currently** take any of the following cholesterol-lowering drugs?

- Lipitor (atorvastatin) Lovastatin (Mevacor or Altoprev) Crestor (rosuvastatin)
 Simvastatin (Zocor) Pravastatin (Pravachol) Lescol or Lescol XL (fluvastatin)
 Livalo (Pitavastatin)

If you marked any of the drugs in **Question 20** above, what total dose per day do you take?

- 1-2 mg 4-5 mg 10 mg 20 mg 40 mg 60 mg 80 mg

- Caduet Vytorin
 Zetia (ezetimibe) Any other cholesterol-lowering drug not listed above, for example:
 Tricor (fenofibrate), Gemfibrozil (Lopid), Questran (cholestyramine)

21. In the **past two years**, have you used any of the following medications on a **regular** basis?

		No	Yes
FOR HEART OR BLOOD PRESSURE:			
Calcium Blocker	<i>for example:</i> Norvasc, Cartia, amlodipine, verapamil, diltiazem, nifedipine	<input type="checkbox"/>	<input type="checkbox"/>
Beta Blocker	<i>for example:</i> Toprol, Coreg, atenolol, metoprolol, carvedilol	<input type="checkbox"/>	<input type="checkbox"/>
ACE Inhibitor	<i>for example:</i> Altace, lisinopril, enalapril, ramipril, quinapril, benazepril	<input type="checkbox"/>	<input type="checkbox"/>
Angiotensin II Receptor Blocker (ARB)	<i>for example:</i> Diovan, Cozaar, Benicar, Atacand, Micardis, Avapro, valsartan, losartan, olmesartan, candesartan, telmisartan, irbesartan	<input type="checkbox"/>	<input type="checkbox"/>
Diuretic	<i>for example:</i> Hydrochlorothiazide, triamterene, furosemide, indapamide	<input type="checkbox"/>	<input type="checkbox"/>
Other	<i>(Mark here if unsure of heart or blood pressure medication category.)</i>	<input type="checkbox"/>	<input type="checkbox"/>
FOR DIABETES OR BLOOD SUGAR:			
Insulin injection or pump		<input type="checkbox"/>	<input type="checkbox"/>
Oral medications		<input type="checkbox"/>	<input type="checkbox"/>
BLOOD THINNERS	<i>for example:</i> Warfarin (Coumadin), Plavix (clopidogrel)	<input type="checkbox"/>	<input type="checkbox"/>
THYROID MEDICATIONS	<i>for example:</i> Synthroid, Levoxyl, Levothroid, Levo-T, (levothyroxine, L-thyroxine)	<input type="checkbox"/>	<input type="checkbox"/>
TAMOXIFEN	<i>for example:</i> Nolvadex	<input type="checkbox"/>	<input type="checkbox"/>
RALOXIFENE	<i>for example:</i> Evista	<input type="checkbox"/>	<input type="checkbox"/>
ANASTROZOLE (Arimidex), LETROZOLE (Femara), or AROMASIN (Exemestane)		<input type="checkbox"/>	<input type="checkbox"/>

22. **During the past year**, on average, how frequently have you taken the following?

	Never, or less than once a month	At least once a month	
		Days per month	Pills per day
Aspirin Baby or low-dose aspirin (162 mg or less)	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Regular or extra strength aspirin (163 mg or more) <i>for example:</i> Bufferin, Anacin, Bayer, Excedrin, Ecotrin	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Ibuprofen <i>for example:</i> Motrin, Advil, Nuprin, Mediprin	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Acetaminophen <i>for example:</i> Tylenol	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Naproxen <i>for example:</i> Aleve, Naprosyn, Anaprox, Vimovo	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Other anti-inflammatory analgesics <i>for example:</i> Mobic, nabumetone, meloxicam, diclofenac, indomethacin	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Celebrex	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

Amount in **each** Celebrex pill
 100 mg 200 mg 400 mg

EXERCISE

23. What is your **normal** walking pace?

- Unable to walk
- Slow (less than 2 mph)
- Normal, average (2 to 2.9 mph)
- Brisk (3 to 3.9 mph)
- Very brisk, striding (4 mph or faster)

24. **During the past year**, what was your **average total time PER WEEK** spent at each of the following activities?

	None	Hours Per Week		
		1-3	4-6	7+
Walking (such as on treadmill, at golf)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bicycling/Stationary bike	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jogging/Running, Lap Swimming, Tennis, Racquetball	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other aerobic exercise (such as elliptical or stair machine, aerobics, dancing)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gardening, Mowing, Planting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight training or resistance exercises (such as free weights or machines like Nautilus)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

25. **During the past year**, what was your **average total time PER DAY** spent sitting or lying down during the day?

		Hours Per Day		
	None	Less than 3	3-6	7+
Sitting or lying watching TV, VCR or DVD	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other sitting or lying (such as driving, reading, at desk or games)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

26. To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?

- Completely Mostly Moderately A little Not at all

27. Do you usually use a cane or walker?

- No Yes

28. Do you have difficulty with your balance? ◆

- No Yes

29. Number of times you have fallen to the ground in the past year:

- None 2 4 10 or more
 1 3 5-9

SCREENING

30. In the **past two years**, have you had any of the following? (If yes, **mark all that apply**.)

	No	Yes, for routine exams	Yes, for symptoms
A physical exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mammogram	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pap smear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colonoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sigmoidoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Colonoscopy: A long tube was inserted into the rectum to examine the entire colon for cancer or other problems. A medicine was given through a needle in your arm to make you sleepy and someone else needed to drive you home. Not the same as a sigmoidoscopy.

Sigmoidoscopy: A short tube was inserted into the rectum to examine the lower part of the colon to check for cancer or other problems. You were awake and not given a medicine to make you sleepy. You were probably able to drive yourself home.

VITAMINS

Multi-vitamins contain 10 or more vitamins and/or minerals. (For example: One-A-Day and Centrum)

31. Do you **currently** take a **multi-vitamin**?

(Please do not include additional individual supplements or eye health vitamins such as OcuVite.)

- No
- Yes →

a. How many multi-vitamin pills do you take per week?

2 or fewer 3-5 6-9 10-14 15 or more

b. Does your multi-vitamin include the following nutrients? (Please check label.)

Selenium	Iron	Lycopene
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes

32. **NOT counting multi-vitamins reported above**, do you regularly take any of the following supplements, individually or in combinations? (If yes, please mark pills **per week** and amount in **each pill**. If you take a supplement with more than one vitamin, please repeat information for each vitamin.)

	Pills Per Week	Amount in Each Pill
Vitamin C	<input type="checkbox"/> No <input type="checkbox"/> Yes → <input style="width: 40px; height: 20px;" type="text"/>	<input type="checkbox"/> 450 mg or less <input type="checkbox"/> 500 mg or more <input type="checkbox"/> Don't know
Vitamin E	<input type="checkbox"/> No <input type="checkbox"/> Yes → <input style="width: 40px; height: 20px;" type="text"/>	<input type="checkbox"/> 250 IU or less <input type="checkbox"/> 300 IU or more <input type="checkbox"/> Don't know
Selenium	<input type="checkbox"/> No <input type="checkbox"/> Yes → <input style="width: 40px; height: 20px;" type="text"/>	<input type="checkbox"/> 135 mcg or less <input type="checkbox"/> 140 mcg or more <input type="checkbox"/> Don't know
Folic Acid	<input type="checkbox"/> No <input type="checkbox"/> Yes → <input style="width: 40px; height: 20px;" type="text"/>	<input type="checkbox"/> 300 mcg or less <input type="checkbox"/> 350 mcg or more <input type="checkbox"/> Don't know
Vitamin B₁₂	<input type="checkbox"/> No <input type="checkbox"/> Yes → <input style="width: 40px; height: 20px;" type="text"/>	<input type="checkbox"/> 200 mcg or less <input type="checkbox"/> 250 mcg or more <input type="checkbox"/> Don't know
Calcium <small>(Include Calcium in Tums, etc.) (1 Tums = 200 mg elemental calcium)</small>	<input type="checkbox"/> No <input type="checkbox"/> Yes → <input style="width: 40px; height: 20px;" type="text"/>	<input type="checkbox"/> 350 mg or less <input type="checkbox"/> 400 mg or more <input type="checkbox"/> Don't know
Vitamin D <small>(In Calcium supplement or separately)</small>	<input type="checkbox"/> No <input type="checkbox"/> Yes → <input style="width: 40px; height: 20px;" type="text"/>	<input type="checkbox"/> 350 IU or less <input type="checkbox"/> 400 IU - 900 IU <input type="checkbox"/> 1000 IU or more
Glucosamine	<input type="checkbox"/> No <input type="checkbox"/> Yes → <input style="width: 40px; height: 20px;" type="text"/>	<input type="checkbox"/> 400 mg or less <input type="checkbox"/> 500 mg or more <input type="checkbox"/> Don't know

33. Have you ever taken the following types of omega-3 supplements at least once per week? Include all forms (such as pills, powders and liquids). (If **NO**, leave blank.)

Fish Oil

- Yes, currently use →
- Only** took in past

Days per week?	Years taken in lifetime?
<input type="checkbox"/> 1-3	<input type="checkbox"/> 0-2
<input type="checkbox"/> 4-6	<input type="checkbox"/> 3-5
<input type="checkbox"/> 7	<input type="checkbox"/> 6+

Flax Seed

- Yes, currently use →
- Only** took in past

Days per week?	Years taken in lifetime?
<input type="checkbox"/> 1-3	<input type="checkbox"/> 0-2
<input type="checkbox"/> 4-6	<input type="checkbox"/> 3-5
<input type="checkbox"/> 7	<input type="checkbox"/> 6+

Thank you for your quick response.

Please return questionnaire in the postage-paid envelope provided to:
CANCER PREVENTION STUDY, PO Box 64735, St. Paul, MN 55164-9661