American Cancer Society®

WOMEN

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

Dear Cancer Prevention Study Participant,

We hope you will take the time to complete and return this **very brief** questionnaire. Your participation and prompt response are critical to the Cancer Prevention Study. Study results are valuable not only to cancer researchers but also to the many people who turn to the American Cancer Society as one of the nation's most trusted cancer resources.

Please verify that the information printed above is your full legal name and correct address and make corrections 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, all information is kept strictly confidential and is used for medical statistical purposes only.

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

☐

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 ☒☐☐☐ or PRINT where applicable: C P S 2
- **To change** an answer, fill in the square and **circle** the square of your preferred answer.
  → Correct: ◉☐■☐ or ⊗☐☒☐

MEDICAL

2. Has a physician ever told you that you had any of the following **conditions** or **cancers**?
(*If not, mark **No**; if yes, mark year **first** diagnosed.*)

◆	NO	Year first diagnosed: BEFORE AUGUST 2009	AUG 2009 TO JULY 2011	AFTER JULY 2011
Fibrocystic or other benign breast disease →	☐	☐	☐	☐
Benign polyp of the colon or rectum →	☐	☐	☐	☐
Basal cell or squamous cell skin cancer →	☐	☐	☐	☐
Breast cancer →	☐	☐	☐	☐
Cancer of the uterus or endometrium →	☐	☐	☐	☐
Lung or bronchial cancer →	☐	☐	☐	☐
Colon or rectal cancer →	☐	☐	☐	☐
Bladder cancer →	☐	☐	☐	☐
Lymphoma →	☐	☐	☐	☐
Other cancer →	☐	☐	☐	☐

(Specify type of other cancer) →

3. **SINCE AUGUST 2009**, have you used **prescription** female replacement hormones?

☐ No ***(Go to Question 4)***

☐ Yes →

a. Are you **currently** using them (within the last month)?

☐ Yes, currently ☐ No, not currently ***(If no, go to Question 4)***

b. Mark the type(s) of hormones you are **currently** using:

☐ Combined estrogen and progestin (in a single pill or patch, or in two pills)
☐ Estrogen alone (in pill or patch)
☐ Vaginal estrogen alone (in cream, tablet or ring)
☐ Other

4. In the **past two years**, have you used any anti-estrogen medications on a **regular** basis?
(For example: Tamoxifen (Nolvadex), Raloxifene (Evista), Arimidex, Femara, or Aromasin)

☐ No ☐ Yes

GENERAL HEALTH

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

☐ Excellent ☐ Fair
☐ Very Good ☐ Poor
☐ Good

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

☐ Excellent ☐ Fair
☐ Very Good ☐ Poor
☐ Good

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

☐ Excellent ☐ Fair
☐ Very Good ☐ Poor
☐ Good

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

☐ Excellent ☐ Fair
☐ Very Good ☐ Poor
☐ Good

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

☐ Excellent ☐ Fair
☐ Very Good ☐ Poor
☐ Good

10. How would you rate your pain on average?

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

11. How would you rate your fatigue on average?

☐ None ☐ Severe
☐ Mild ☐ Very Severe
☐ Moderate

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

☐ Never ☐ Often
☐ Rarely ☐ Always
☐ Sometimes

13. 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

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

☐☐☐ Pounds

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

☐ No ☐ Yes

16. 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	☐	☐	☐
Mammogram	☐	☐	☐
Pap smear	☐	☐	☐
Colonoscopy	☐	☐	☐
Sigmoidoscopy	☐	☐	☐

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

Do you **currently** take a **multi-vitamin**? (Please do not include 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 ☐ 6-9 ☐ 15 or more
☐ 3-5 ☐ 10-14

18. **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	At least once a month: Pills per day
Aspirin Baby or low-dose aspirin (162 mg or less)		☐		
Regular or extra strength aspirin (163 mg or more)	*for example:* Bufferin, Anacin, Bayer, Excedrin, Ecotrin	☐		
Ibuprofen	*for example:* Motrin, Advil, Nuprin, Mediprin	☐		
Acetaminophen	*for example:* Tylenol	☐		
Naproxen	*for example:* Aleve, Naprosyn, Anaprox, Vimovo	☐		
Other anti-inflammatory analgesics	*for example:* Mobic, nabumetone, meloxicam, diclofenac, indomethacin	☐		
Celebrex		☐		

19. 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)	☐	☐	☐	☐
Myocardial infarction (heart attack) or angina pectoris	☐	☐	☐	☐
Hospitalized for MI →	☐	☐	☐	☐
Coronary bypass, angioplasty or stent	☐	☐	☐	☐
Stroke (CVA) or TIA (Transient ischemic attack)	☐	☐	☐	☐
Carotid surgery (Endarterectomy)	☐	☐	☐	☐
Parkinson's Disease	☐	☐	☐	☐
ALS (Lou Gehrig's Disease)	☐	☐	☐	☐
Emphysema or chronic bronchitis	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐
Wrist fracture, vertebral fracture or hip fracture	☐	☐	☐	☐
Osteoarthritis or Rheumatoid arthritis	☐	☐	☐	☐

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