

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 **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 research purposes only.

If you have any questions about the survey, please call us at 1-800-646-7853.

Sincerely,

Son - M. Ma

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

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.

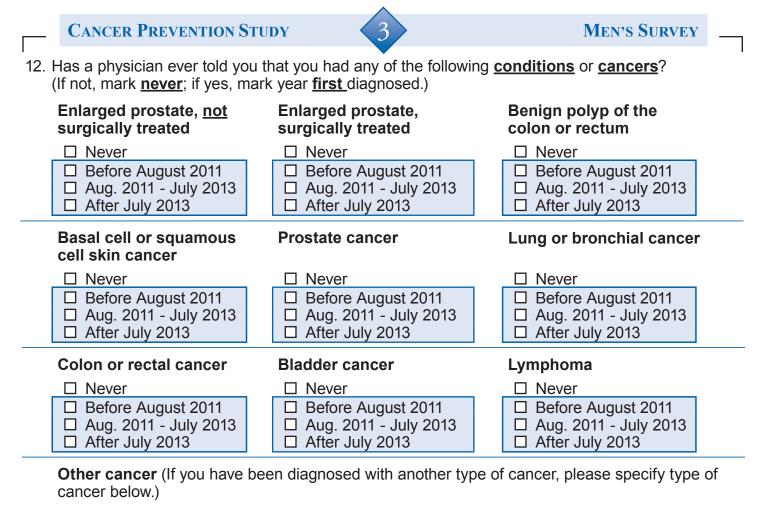
The answers to the following questions should be provided by the person named above. If someone else provides the answers **about that person**, please mark this square.

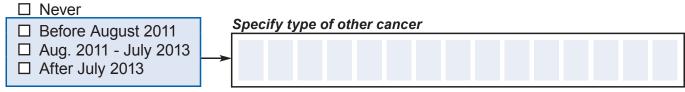
START HERE	
 1. Is this your correct date of birth? Pes No, my birthday is: ///////////////////////////////////	 Please print your phone number below. We will <u>not</u> release it to anyone. Area Code
Month Day Year	

CANCER PREVENTION ST	UDY	2		Men's Survey				
 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. To change an answer, fill in the square and circle the square of your preferred answer. Correct: O or O O O 								
 3. In general, would you say your health is: □ Excellent □ Very good □ Good □ Fair □ Poor 								
 4. To what extent are you able to □ Completely □ Mostly 		rry out everyda ∃ Moderately		s (climb stairs, carry groceries, etc.)? ttle □ Not at all				
5. During the past year, what w	as v	your <u>average 1</u>	time PER	WEEK spent walking?				
□ None □ 1-3 hours/wee				□ 7+ hours/week				
 <u>During the past year</u>, on ave TV, reading, while driving, etc 	rage .)?	e, how many <u>h</u>	ours PER	DAY did you spend sitting (watching				
□ None □ Less than 3 hrs/	′day	□ 3-5 hrs/d	ay □ 6-8	8 hrs/day 🛛 More than 8 hrs/day				
7. What is your <u>current</u> weight?		Pou	inds					
8. Do you <u>currently</u> smoke ciga	rette	es? 🗆 No	□ Yes					
 ♦ 9. On average, how often did you drink beer, wine or liquor in the last year? □ Never or less than 1 day/month □ 1-4 days/month □ 2-5 days/week □ 6-7 days/week 								
10. On average, on the days that	at yo	ou drank beer	, wine, or	liquor, how many drinks did you have?				
□ I don't drink alcohol □ 1	drin	k/day □ 2 di	rinks/day	□ 3 or more drinks/day				
11. 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	Colonoscopy: A long tube inserted				
A physical exam				into the rectum to examine the entire colon for cancer or other problems. A				
Colonoscopy				medicine was given through a needle in your arm to make you sleepy and				
Sigmoidoscopy				someone else needed to drive you home.				
A prostate biopsy				Sigmoidoscopy: A short tube				
PSA blood test for prostate cancer screening		P	P	inserted into the rectum to examine the lower part of the colon to check				

If "**yes**" for PSA screening, was your PSA elevated?

for cancer or other problems. You were awake and <u>not</u> given a medicine to make you sleepy. You were probably able to drive yourself home.





13. Has a physician ever told you that you had any of the following? (If <u>NO</u>, leave blank. If yes, mark the <u>yes</u> square Mark and year of diagnosis for each illness)

Year first diagnosed

Aftor

Before Aug 2011

and <u>year of diagnosis</u> for each illness.)	here for YES	August 2011	to July 2013	July 2013
Diabetes mellitus	□ Yes		🛛	
Use insulin injection or pump ———→	□ Yes			
_Myocardial infarction (heart attack) or angina pectoris _ Hospitalized for MI>	□ Yes □ Yes	□	🛛	
Coronary bypass, angioplasty or stent	□ Yes			
Stroke (CVA) or TIA (Transient ischemic attack)	□ Yes			
Carotid surgery (Endarterectomy)	□ Yes			
Parkinson's Disease	□ Yes			
Emphysema or chronic bronchitis	□ Yes			
Wrist fracture, vertebral fracture or hip fracture	□ Yes			
Rheumatoid arthritis	□ Yes			



Never or less

At least once a month

14. During the past year, on average, how frequently have

you taken the following?		ivever, or less		
you taken the following?		than once a month	Days per month	Pills per day
Aspirin Baby or low-dose aspirin	(162 mg or less)			
Regular or extra strength aspirin (163 mg or more)	<i>example:</i> Bufferin, Anacin, Bayer Excedrin, Ecotrin			
Ibuprofen	<i>example:</i> Motrin, Advil, Nuprin, Mediprin			
Acetaminophen	example: Tylenol			
Celebrex				
Other anti-inflammatory pain relievers	<i>example:</i> Aleve, naproxen, mobio nabumetone, meloxicar diclofenac, indomethac	n, □		

Multi-vitamins contain 10 or more vitamins and/or minerals. (For example: One-A-Day and Centrum) Please do not include individual supplements or eye health vitamins such as Ocuvite.

15. Do you currently take a multi-vitamin ?	□ No	□ Yes	-			
How many multi-vitamin pills do you take per	week?	□≤2	□ 3-5	□ 6-9	□ 10-14	□ 15 or more

16. NOT counting multi-vitamins reported above, do you regularly take either of the following?

		Pills Amount in Each Pill
Calcium (Include Calcium in Tums, etc.) (1 Tums = 300 mg elemental calcium)	□ No	$\Box \text{ Yes} \longrightarrow \Box \xrightarrow{350 \text{ mg}} \Box \xrightarrow{400 \text{ mg}} \Box \xrightarrow{\text{Don't}}_{\text{know}}$
Vitamin D (In Calcium supplement or separately)	□ No	$\Box \text{ Yes} \longrightarrow \Box \xrightarrow[]{350 \text{ IU}} \Box \xrightarrow[]{400 \text{ IU}} \Box \xrightarrow[]{1000 \text{ IU}} \text{ or more}$

17. Have you ever taken Fish Oil supplements at least once per week? (If NO, leave blank.)

□ Yes, currently use	Days <u>per week</u> ?	□ 1-3	□ 4-6	□ 7
Only took in past				

Thank You. Please return questionnaire in the postage-paid envelope to: CANCER PREVENTION STUDY, PO Box 5836, HOPKINS, MN 55343-9525