



CANCER PREVENTION STUDY-II 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 **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,

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?

Yes →

No, my birthday is:
 / /
Month Day Year



- 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 placing an X or ✓ in the square.
- **To change** an answer, fill in the square and **circle** the square of your preferred answer.
 ↳ Correct: or

2. In general, would you say your health is:
- Excellent Very good Good Fair Poor
3. To what extent are you able to carry out everyday activities (climb stairs, carry groceries, etc.)?
- Completely Mostly Moderately A little Not at all
4. Do you usually use a cane, walker or wheelchair? No Yes
5. **During the past year**, what was your **average time PER WEEK** spent walking?
- None 1-3 hours/week 4-6 hours/week 7+ hours/week
6. **During the past year**, on average, how many **hours PER DAY** did you spend sitting (watching TV, reading, while driving, etc.)?
- None Less than 3 hrs/day 3-5 hrs/day 6-8 hrs/day More than 8 hrs/day



7. What is your **current** weight? pounds
8. What is your **current** height? feet inches
- ↳ Was this height measured in the last 5 years? No Yes
9. Do you **currently** smoke cigarettes? No Yes

10. 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 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.

Sigmoidoscopy: A short tube 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.

11. Has a physician ever told you that you had any of the following **conditions** or **cancers**?
(If not, mark **never**; if yes, mark year **first** diagnosed.)

Fibrocystic or other benign breast disease

- Never
- Before August 2013
- Aug. 2013 - July 2015
- After July 2015

Benign polyp of the colon or rectum

- Never
- Before August 2013
- Aug. 2013 - July 2015
- After July 2015

Basal cell or squamous cell skin cancer

- Never
- Before August 2013
- Aug. 2013 - July 2015
- After July 2015

Breast cancer

- Never
- Before August 2013
- Aug. 2013 - July 2015
- After July 2015

Cancer of the uterus or endometrium

- Never
- Before August 2013
- Aug. 2013 - July 2015
- After July 2015

Lung or bronchial cancer

- Never
- Before August 2013
- Aug. 2013 - July 2015
- After July 2015

Colon or rectal cancer

- Never
- Before August 2013
- Aug. 2013 - July 2015
- After July 2015

Bladder cancer

- Never
- Before August 2013
- Aug. 2013 - July 2015
- After July 2015

Lymphoma

- Never
- Before August 2013
- Aug. 2013 - July 2015
- After July 2015

Other cancer (If you have been diagnosed with another type of cancer, please specify type of cancer below.)

- Never
- Before August 2013
- Aug. 2013 - July 2015
- After July 2015

Specify type of other cancer

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

	Mark here for YES	Year first diagnosed		
		Before August 2013	Aug 2013 to July 2015	After July 2015
Diabetes mellitus	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use insulin injection or pump →	<input type="checkbox"/> Yes			
Myocardial infarction (heart attack) or angina pectoris	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalized for MI →	<input type="checkbox"/> Yes			
Heart failure (congestive)	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronary bypass, angioplasty or stent	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke (CVA) or TIA (Transient ischemic attack)	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carotid surgery (Endarterectomy)	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's disease	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema, chronic bronchitis or COPD	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wrist fracture, vertebral fracture or hip fracture	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13. Are you **currently** using **prescription** female replacement hormones? No Yes

14. Are you **currently** using any **prescription** anti-estrogen medications such as Tamoxifen, Raloxifene (Evista), Anastrozole, Letrozole or Exemestane? No Yes

15. **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="checkbox"/>	<input type="checkbox"/>
Regular or extra strength aspirin (163 mg or more)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ibuprofen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acetaminophen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Celebrex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other anti-inflammatory pain relievers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. Are you **currently** using a **blood thinner** (not including Aspirin), such as Warfarin (Coumadin), Clopidogrel (Plavix), Xarelto or Pradaxa? No Yes

17. Do you **currently** take a **multi-vitamin** (containing 10 or more vitamins)? (Do not include other supplements) No Yes ↴

How many multi-vitamin pills do you take **per week**? ≤ 2 3-5 6-9 10-14 15 or more

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

	Pills Per Week	Amount in Each Pill
Calcium (Include calcium in Tums, etc.)	<input type="checkbox"/> No <input type="checkbox"/> Yes → <input type="checkbox"/>	<input type="checkbox"/> 350 mg or less <input type="checkbox"/> 400 mg or more <input type="checkbox"/> Don't know
Vitamin D (In calcium supplement or separately)	<input type="checkbox"/> No <input type="checkbox"/> Yes → <input type="checkbox"/>	<input type="checkbox"/> 350 IU or less <input type="checkbox"/> 400 IU - 900 IU <input type="checkbox"/> 1000 IU or more

19. Do you **currently** take **Fish Oil** supplements at least once per week?

No Yes → If yes, days **per week**? 1-3 4-6 7

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