AMERICAN CANCER SOCIETY

CANCER PREVENTION STUDY

QUESTIONNAIRE FOR MEN

Division No.	Unit No.	Group No.
1-2	3-5	6-8
Researcher No.	**Family No.**	**Person No.**
9-11	12-13	14-15

1. Name: ______________ 17-18 2. Date 16 ______

3. Date of Birth: Month: ______ Year: ______ 20-22 4. Present Weight (Indoor clothing): ______ lbs.

5. Height (Without shoes): 26-27 ___ ft. ___ in. 6. Race: 28 White ☐ Negro ☐ Indian ☐ Other: ______

7. Marital Status: 29 Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐

FAMILY HISTORY (IN RELATION TO CANCER): Please indicate for each of the following members of your family: whether living or dead; their present age or age at time of death; and whether or not they ever had cancer.

1. Your Parents and Grandparents:
   - (a) Father: Alive ☐ 30 Dead ☐ ; Age 31 ___; Cancer: Yes ☐ No ☐ ; Type of Cancer ______
   - b) Mother: Alive ☐ Dead ☐ ; Age 34 ___; Cancer: Yes ☐ No ☐ ; Type of Cancer ______
   - c) Father's father: Alive ☐ Dead ☐ ; Age (approximate): 37 ___; Cancer: 38 Yes ☐ No ☐ Don't know ☐
   - d) Father's mother: Alive ☐ Dead ☐ ; Age (approximate): 39 ___; Cancer: 40 Yes ☐ No ☐ Don't know ☐
   - e) Mother's father: Alive ☐ Dead ☐ ; Age (approximate): 41 ___; Cancer: 42 Yes ☐ No ☐ Don't know ☐
   - f) Mother's mother: Alive ☐ Dead ☐ ; Age (approximate): 43 ___; Cancer: 44 Yes ☐ No ☐ Don't know ☐

2. Your Brothers: (Please list all of them, living or dead). - No. of brothers - 45
   - a) Alive ☐ or Dead ☐ ; Age 47 ___; Cancer: Yes ☐ No ☐ ; Type of Cancer 48-49
   - b) Alive ☐ or Dead ☐ ; Age ___; Cancer: Yes ☐ No ☐ ; Type of Cancer ______
   - c) Alive ☐ or Dead ☐ ; Age ___; Cancer: Yes ☐ No ☐ ; Type of Cancer 56-57
   - d) Alive ☐ or Dead ☐ ; Age ___; Cancer: Yes ☐ No ☐ ; Type of Cancer ______
   - e) Alive ☐ or Dead ☐ ; Age ___; Cancer: Yes ☐ No ☐ ; Type of Cancer ______

3. Your Sisters: (Please list all of them, living or dead).
   - a) Alive ☐ or Dead ☐ ; Age ___; Cancer: Yes ☐ No ☐ ; Type of Cancer ______
   - b) Alive ☐ or Dead ☐ ; Age ___; Cancer: Yes ☐ No ☐ ; Type of Cancer ______
   - c) Alive ☐ or Dead ☐ ; Age ___; Cancer: Yes ☐ No ☐ ; Type of Cancer ______
   - d) Alive ☐ or Dead ☐ ; Age ___; Cancer: Yes ☐ No ☐ ; Type of Cancer 89-90
   - e) Alive ☐ or Dead ☐ ; Age ___; Cancer: Yes ☐ No ☐ ; Type of Cancer 93-94

4. Do you (or did you) have a twin brother? Yes ☐ No ☐ If "yes," indicate above which brother.

5. When you were born: How old was your mother? 99 ______ How old was your father? ______

HISTORY OF DISEASES:

1. Have you ever had cancer? Yes ☐ No ☐
   If "Yes,": a) What type of cancer ______ b) Date of first treatment: ______

2. Please make a check mark after the name of each of the following diseases you have ever had:

   Pneumonia ☐ Tuberculosis ☐ Bronchitis ☐ Influenza ☐ Laryngitis ☐ Tonsillitis ☐
   Asthma ☐ Hay Fever ☐ Dysentery ☐ Stomach Ulcer ☐ Duodenal Ulcer ☐ Diabetes ☐
   Heart Disease ☐ Stroke ☐ High Blood Pressure ☐ Rheumatic Fever ☐ Cirrhosis of Liver ☐
   Gallstones ☐ Arthritis ☐ Poliomyelitis ☐ Goiter ☐ Enlarged Prostate ☐

   Any serious disease not listed above: (please specify): ______________

3. How often have you had colds (or grippe) in the last year? ______

4. Have you ever had a surgical operation? Yes ☐ No ☐ Summary-129

If "yes," please specify type of operation(s): 130 - 133

5. Have you ever had an X-ray or fluoroscopic examination of your stomach or abdomen? 136 Yes ☐ No ☐

6. Have you ever been treated with radium, X-rays, or radioactive isotopes? 137 Yes ☐ No ☐

If "yes," what part of your body? _____

What disease were you treated for? _____

PRESENT PHYSICAL COMPLAINTS: Please check "yes" or "no" after each complaint listed. If you check "yes," please indicate the severity of the condition.

1. 138 A Cough: Yes ☐ No ☐ Slight ☐ Moderate ☐ Severe ☐	10. 144 Blood in the Stool: Yes ☐ No ☐ Seldom ☐ Fairly Often ☐ Often ☐	19. 147 Headaches: Yes ☐ No ☐ Seldom ☐ Fairly Often ☐ Often ☐
2. 139 Sore Throat: Yes ☐ No ☐ Slight ☐ Moderate ☐ Severe ☐	11. 144 Pain or Discomfort in Lower Abdomen: Yes ☐ No ☐ Seldom ☐ Fairly Often ☐ Often ☐	20. 147 Dizziness: Yes ☐ No ☐ Seldom ☐ Fairly Often ☐ Often ☐
3. 139 Hoarseness: Yes ☐ No ☐ Slight ☐ Moderate ☐ Severe ☐	12. 144 Pain in Stomach: Yes ☐ No ☐ Seldom ☐ Fairly Often ☐ Often ☐	21. 147 Insomnia: Yes ☐ No ☐ Degree: 158 Seldom ☐ Fairly Often ☐ Often ☐
4. 140 Shortness of Breath: Yes ☐ No ☐ Slight ☐ Moderate ☐ Severe ☐	13. 145 Indigestion: Yes ☐ No ☐ Degree: 154 Slight ☐ Moderate ☐ Severe ☐	22. Fatigue Easily: Yes ☐ No ☐ Slight ☐ Moderate ☐ Severe ☐
5. 141 Pain or Discomfort in Chest: Yes ☐ No ☐ Slight ☐ Moderate ☐ Severe ☐	14. 145 Nausea or Vomiting: Yes ☐ No ☐ Degree: 155 Seldom ☐ Fairly Often ☐ Often ☐	23. Change in Weight: Yes ☐ No ☐ 149 If "yes," did you: Lose weight ☐ Gain weight ☐ 150 About how many pounds? _____ 151 Over what period of time? _____ 152 Did you try to bring about this change? Yes ☐ No ☐
6. 142 Difficulty in Swallowing: Yes ☐ No ☐ Slight ☐ Moderate ☐ Severe ☐	15. 145 Loss of Appetite: Yes ☐ No ☐ Degree: 156 Slight ☐ Moderate ☐ Severe ☐	
7. 143 Constipation: Yes ☐ No ☐ Slight ☐ Moderate ☐ Severe ☐	16. 146 Blood in the Urine: Yes ☐ No ☐ Degree: 157 Seldom ☐ Fairly Often ☐ Often ☐	24. Other Complaints: Yes ☐ No ☐ Please specify:
8. 142 Diarrhea: Yes ☐ No ☐ Slight ☐ Moderate ☐ Severe ☐	17. 146 Difficulty in Urinating: Yes ☐ No ☐ Slight ☐ Moderate ☐ Severe ☐	
9. 142 Recent Change in Bowel Habits: Yes ☐ No ☐ Degree: 153 Slight ☐ Moderate ☐ Severe ☐	18. 146 Too Frequent Urination: Yes ☐ No ☐ Slight ☐ Moderate ☐ Severe ☐	

25. Have you been a doctor in the last year about any of the complaints listed above? Yes ☐ No ☐

If "yes," which complaint(s)? _____

26. Have you had difficulty with constipation over a period of many years? Yes ☐ No ☐ 160

27. Have you had a cough over a period of many years? Yes ☐ No ☐

28. How have you been feeling in the last month or two? Good ☐ Fair ☐ Poor ☐ 161

29. Are you sick at the present time? Yes ☐ No ☐

If "yes," what disease? _____

162-176, 178 Blank for male

HABITS:

179 1. How much exercise do you get (work or play): None ☐ Slight ☐ Moderate ☐ Heavy ☐

180 2. How many hours of sleep do you usually get a night?_____

181 3. Do you now smoke? Yes ☐ No ☐

182 If "yes,": a) How many cigarettes do you usually smoke a day?_____

183 b) How many cigars do you usually smoke a day?_____

c) How many pipefuls of tobacco do you usually smoke a day?_____

4. If you now smoke cigarettes:

184 a) About how much do you inhale when smoking cigarettes?

Do not inhale ☐ Inhale Slightly ☐ Inhale Moderately ☐ Inhale Deeply ☐

185 b) What type do you smoke? Filter-tip ☐ Without filter-tip ☐

c) What brand do you usually smoke?_____

186 d) How old were you when you started smoking cigarettes?_____

5. If you now smoke cigars, about how much do you inhale when smoking cigars?

184 Do Not Inhale ☐ Inhale Slightly ☐ Inhale Moderately ☐ Inhale Deeply ☐

6. If you now smoke a pipe, about how much do you inhale when smoking a pipe?

184 Do Not Inhale ☐ Inhale Slightly ☐ Inhale Moderately ☐ Inhale Deeply ☐

7. If you do not smoke cigarettes now, did you ever smoke cigarettes regularly? Yes ☐ No ☐

If "yes,": 187 a) How long has it been since you last smoked cigarettes regularly?_____

b) How many cigarettes did you usually smoke per day?_____

c) Why did you stop smoking cigarettes?_____

188 8. If you do not smoke cigars now, did you ever smoke cigars regularly? Yes ☐ No ☐

9. If you do not smoke a pipe now, did you ever smoke a pipe regularly? Yes ☐ No ☐

189 10. Do you chew tobacco or use snuff? Never ☐ Occasionally ☐ Regularly ☐

11. How many days a week do you eat each of the following foods?

Fish 192; Meat or poultry_____; Eggs 192; Cheese 192; Butter or oleomargarine 194;

Bread, rolls, or biscuits_____; Pancakes 194; Cereal 197; Spaghetti or macaroni 199;

Potatoes 199; Rice_____; Cooked vegetables 201; Green salads 202; Fruits or fruit juices 203

Sweet desserts_____; Candy_____.

204 12. When eating meat, do you avoid eating the fat? Yes ☐ No ☐

13. How many days a week do you eat each of the following fried foods:

Fried eggs_____; Fried bacon, fried sausage, or fried ham_____; Fried potatoes_____;

Fried chicken or fried fish_____; Other fried food_____.

207 14. Do you often add salt to your food? Yes ☐ No ☐; Pepper? Yes ☐ No ☐

Catsup, mustard, or spices? Yes ☐ No ☐; Mayonnaise or salad oil? Yes ☐ No ☐

208 15. Do you often eat: Ham? Yes ☐ No ☐; Pork chops? Yes ☐ No ☐; Other Pork? Yes ☐ No ☐

Frankfurters? Yes ☐ No ☐; Smoked or Salt fish? Yes ☐ No ☐

16. How many cups, glasses, or "drinks" of the following beverages do you usually take a day?

a) Milk 210; b) Coffee 211; c) Tea 212; d) Soft drinks 214;

e) Beer 217; f) Wine 218; g) Whiskey, gin, etc. 219.

220 17. When drinking coffee, tea, or soup, do you take it: Very hot ☐ Moderately hot ☐ Lukewarm ☐

18. How often do you use the following types of medicine?

Aspirin, Bufferin...Never ☐ Seldom ☐ Often ☐; 221 Tranquilizers.....Never ☐ Seldom ☐ Often

222 Vitamin pills .....Never ☐ Seldom ☐ Often ☐; Laxatives.....Never ☐ Seldom ☐ Often

223 Sleeping pills .....Never ☐ Seldom ☐ Often ☐; Anti-acid medicine.....Never ☐ Seldom ☐ Often

MISCELLANEOUS:

226 1. What is your present occupation?_____

227 If retired, what was your previous occupation?_____

2. In your work, have you ever been exposed to gases, dusts, or fumes of any sort which might poss
fect your lungs? (Examples: painters are often exposed to fumes from solvents; some farmers are
to insecticide sprays; etc.) Yes ☐ No ☐

228 If "yes," please describe:_____

3. In your work, have you ever been exposed to any chemicals, solvents, or oil products not mention
preceding question? Yes ☐ No ☐

If "yes," please describe:_____

4. Have you ever worked with X-rays or radioactive material? Yes ☐ No ☐

If "yes," please describe briefly:_____

229 5. Many people complain that their work or home situation puts them under pressure or nervous tensi
much pressure or nervous tension do you feel you are under?

None ☐ Slight ☐ Moderate ☐ Severe ☐

230 6. Have you recently noticed any change in the size or color of a mole or wart? Yes ☐ No ☐

231 7. Has a doctor ever removed a mole or wart from your skin? Yes ☐ No ☐

232 8. Do you have a sore which will not heal? Yes ☐ No ☐ If "yes," where:_____

233 234 9. How many teeth have you lost?_____

235 10. Do you wear a full dental plate? Yes ☐ No ☐ A partial dental plate? Yes ☐ No ☐

236 11. Are you bald or beginning to get bald? Yes ☐ No ☐

If "yes," how bald? Slight ☐ Moderate ☐ Much ☐

237 12. Are you circumcised?

Completely circumcised (foreskin absent) ☐ Some foreskin ☐

Uncircumcised (full foreskin) ☐ Don't know ☐

177 13. Frequency of sexual intercourse (times per month):_____

240 14. Religion: Protestant ☐ Catholic ☐ Jewish ☐ Other:_____

If Protestant, what denomination?_____

(We ask this because cancer of some sites is said to be rare in certain religious groups.
For example, cancer of the penis is rare in Jewish men.)

239 15. Did you ever live in a house with a person who had cancer? Yes ☐ No ☐

If "yes," what was his or her relationship to you?_____

241 16. Do you have a medical check-up regularly every year? Yes ☐ No ☐

242 17. Where were you born?_____

243 18. How many years have you lived in your present neighborhood?_____

244 19. Education: Grammar School ☐ Some High School ☐ High School Graduate ☐ Some College ☐
College Graduate ☐

245 20. Did the person whose name appears on the first page of this questionnaire fill out the questionnaire
himself? Yes ☐ No ☐

REMARKS: