AMERICAN CANCER SOCIETY
CANCER PREVENTION STUDY
QUESTIONNAIRE FOR WOMEN

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

1. Name: ____________________________
   Date of birth: Month: ______ Year: ______
   Present Weight: __________ lbs.
   Height (without shoes): ______ ft. ______ in.
   Race: White □ Negro □ Indian □ Other: ______
   Marital Status: Single □ Married □ Widowed □ Divorced □ Separated □

2. Date ______ 16
   Index: ______

3. If now married, did you have a previous marriage? Yes □ No □

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 □ Dead □ Age: ______; Cancer: Yes □ No □; Type of Cancer: ______
   b) Mother: Alive □ Dead □ Age: ______; Cancer: Yes □ No □; Type of Cancer: ______
   c) Father's father: Alive □ Dead □ Age: ______; Cancer: Yes □ No □; Type of Cancer: ______
   d) Father's mother: Alive □ Dead □ Age: ______; Cancer: Yes □ No □; Type of Cancer: ______
   e) Mother's father: Alive □ Dead □ Age: ______; Cancer: Yes □ No □; Type of Cancer: ______
   f) Mother's mother: Alive □ Dead □ Age: ______; Cancer: Yes □ No □; Type of Cancer: ______

2. Your Brothers: (Please list all of them, living or dead). No. of brothers - ______
   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: ______
   e) Alive □ or Dead □; Age: ______; Cancer: Yes □ No □; Type of Cancer: ______
   f) Alive □ or Dead □; Age: ______; Cancer: Yes □ No □; Type of Cancer: ______

3. Your Sisters: (Please list all of them, living or dead). No. of sisters - ______
   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: ______
   e) Alive □ or Dead □; Age: ______; Cancer: Yes □ No □; Type of Cancer: ______
   f) Alive □ or Dead □; Age: ______; Cancer: Yes □ No □; Type of Cancer: ______

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

5. When you were born: How old was your mother? ______
   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 □
   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):  130-135

5. Have you ever had an X-ray or fluoroscopic examination of your stomach or abdomen?  Yes □  No □
6. Have you ever been treated with radium, X-rays, or radioactive isotopes?  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.

| 2. Sore Throat: | Yes □  No □ | 11. Pain or Discomfort in Lower Abdomen: Yes □  No □ | 20. Unusual Discharge from Vagina: Yes □  No □ |
| 8. Diarrhea: Yes □  No □ | 17. Severe: Yes □  No □ | 20. Change in Weight: Yes □  No □ |
| 9. Recent change in Bowel Habits: Yes □  No □ | 18. Degree: 15° | 21. If "yes," did you:
   a. Lose weight □  Gain weight □ |
   b. About how many pounds?
   c. Over what period of time?
   d. Did you try to bring about
      this change? Yes □  No □ |

27. Have you seen a doctor in the last year about any of the complaints listed above? Yes □  No □
   If "yes," which complaint(s)? _________

28. Have you had difficulty with constipation over a period of many years? Yes □  No □

29. Have you had a cough over a period of many years? Yes □  No □

30. How have you been feeling in the last month or two? Good □  Fair □  Poor □

31. Are you sick at the present time? Yes □  No □
   If "yes," what disease? _________
154. Menstruation when you were about 20 years old:
   a) Regular □ or Irregular □
   b) Usual number of days of flow: __________
   c) How painful? None □ Slight □ Moderate □ Severe □

155. Menstruation in recent months:
   a) Regular □ Irregular □ Pregnant □ Past Menopause □
   b) Usual number of days of flow: __________
   c) How painful? None □ Slight □ Moderate □ Severe □

156. If past menopause: a) Age when menopause began: __________
   b) Did you have excessive bleeding during menopause? Yes □ No □

157. Number of children born alive: __________ Number stillborn (carried at least 6 months): __________
   Number miscarriages (carried less than 6 months): __________

158. Your age at time of first pregnancy: __________

159. Breast feeding of children. a) Number breast fed for over 2 months: __________
   b) Number breast fed for from 2 weeks to 2 months: __________
   c) Number breast fed for less than 2 weeks: __________
   d) Number never breast fed: __________

160. Did you ever take medicine to prevent the flow of milk? Yes □ No □

161. If you did not breast feed one or more of your children, why not?
   Lack of milk □ Painful nipple □ Breast Abscess □ Preferred Not To □ Other: __________

162. If you are now married: Frequency of intercourse (times per month): __________

163. Did you ever have an X-ray or fluoroscopic examination of your abdomen when pregnant? Yes □ No □

HABITS: Blank □ from Jan 151 to Aug 159

164. How much exercise do you get (work or play)? None □ Slight □ Moderate □ Heavy □

165. How many hours of sleep do you usually get at night? __________

3. Do you now smoke? Yes □ No □

164. If "yes": a) How many cigarettes do you usually smoke a day? __________
   b) About how much do you inhale when smoking cigarettes?
      Do not inhale □ Inhale slightly □ Inhale moderately □ Inhale deeply □
   c) What type do you smoke? Filter-tip □ Without filter-tip □
   d) What brand do you usually smoke? __________

166. e) How old were you when you started smoking cigarettes? __________

4. If you do not smoke cigarettes now, did you ever smoke cigarettes regularly? Yes □ No □

If "yes," (167a) How long has it been since you last smoked cigarettes regularly? __________

168b) How many cigarettes did you usually smoke per day? __________
   c) Why did you stop smoking cigarettes? __________

5. How many days a week do you eat each of the following foods?
   Fish __________ Meat or poultry __________ Eggs __________ Cheese __________ Butter or oleomargarine __________
   Bread, rolls, or biscuits __________ Pancakes __________ Cereal __________ Spaghetti or macaroni __________
   Potatoes __________ Rice __________ Cooked vegetables __________ Green salads __________ Fruits or fruit juices __________
   Sweet desserts __________ Candy __________
2066. When eating meat, do you avoid eating the fat? Yes □ No □
2077. 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 □.
2078. Do you save grease, lard, oil, etc. and use it repeatedly for frying? Yes □ No □
2079. Do you often add salt to your food? Yes □ No □: Pepper? Yes □ No □
210. Catsup, mustard, or spices? Yes □ No □: Mayonnaise or salad oil? Yes □ No □
2110. Do you often eat: Ham? Yes □ No □: Pork chops? Yes □ No □: Other pork? Yes □ No □
2112. Frankfurters? Yes □ No □: Smoked or salt fish? Yes □ No □
11. How many cups, glasses, or "drinks" of the following beverages do you usually take a day?
   e) Beer 217: f) Wine 218: g) Whiskey, gin, etc. 219.
2212. When drinking coffee, tea, or soup, do you take it: Very hot □ Moderately hot □ Luke □
2113. Do you have to avoid certain foods or drinks because they give you indigestion? Yes □ No □
   If "yes," what foods or drinks?
14. How often do you use the following types of medicine?
2415. Do you have a medical check-up regularly every year? Yes □ No □

MISCELLANEOUS:
2241. What is your present occupation: ________________________________
217. If retired, what was your previous occupation: ______________________
2. Many people complain that their work or home situation puts them under pressure or nervous tension
229. How much pressure or nervous tension do you feel you are under?
   None □ Slight □ Moderate □ Severe □
223. Have you recently noticed any change in the size or color of a mole or wart? Yes □ No □
224. Do you have a sore which will not heal? Yes □ No □. If "yes," where:
225. How many teeth have you lost? ________________________________
225. Do you wear a full dental plate? Yes □ No □: A partial dental plate? Yes □ No □
2257. 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: ___________________________
2318. Has a child of yours had cancer (including leukemia)? Yes □ No □. If "yes," what type:
2409. 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 cervix is rare in Jewish women.)
2410. Where were you born? ________________________________
2411. Education: Grammar school □ Some high school □ High school graduate □ Some college □
   College graduate □
2412. Did the person whose name appears on the first page of this questionnaire fill out this questionnaire
   herself? Yes □ No □

REMARKS: __________________________________________________________________________