AMERICAN CANCER SOCIETY **CANCER PREVENTION STUDY II** **QUESTIONNAIRE FOR WOMEN** 	Division No.	Unit No.	Group No.
	Researcher No.	Family No.	Person No.

Date: _____

1. Name: _____
2. Date of birth: Month _____ Year _____
3. How old are you now? _____
4. Current weight with indoor clothing: _____ lbs.
5. Weight 1 year ago: _____ lbs.
6. Height (without shoes): _____ ft. _____ in.
7. ☐ White ☐ Black ☐ Hispanic ☐ Oriental ☐ Other _____ (specify)
8. Marital status: ☐ Single ☐ Separated ☐ Widowed ☐ Married ☐ Divorced
9. If ever married, age at first marriage: _____
10. Number of times married: _____
11. Social Security No.: _____ (optional)

FAMILY HISTORY (IN RELATION TO CANCER):

1. Fill in the following table as completely as possible for parents, brothers and sisters.

LIST ONE BLOOD RELATIVE PER LINE: (Circle Brother **or** Sister)	IS THIS PERSON? (Circle One)	IF ALIVE, GIVE AGE	IF DEAD, GIVE AGE AT DEATH	DID THIS PERSON **EVER** HAVE CANCER? (Circle One)	IF "YES," SPECIFY TYPE OF CANCER	AT WHAT AGE?
Father	Alive Dead			Yes No		
Mother	Alive Dead			Yes No		
Brother or Sister	Alive Dead			Yes No		
Brother or Sister	Alive Dead			Yes No		
Brother or Sister	Alive Dead			Yes No		
Brother or Sister	Alive Dead			Yes No		
Brother or Sister	Alive Dead			Yes No		
Brother or Sister	Alive Dead			Yes No		

2. When you were born, a) How old was your mother? _____ b) How old was your father? _____

HISTORY OF DISEASES:

1. Have you ever had cancer? ☐ Yes ☐ No. If "yes,"
   a) What type? _____
   b) Date of first treatment: _____
2. Place a check-mark by the following diseases or conditions for which you have ever been diagnosed by a doctor:
   - ☐ High Blood Pressure
   - ☐ Heart Disease
   - ☐ Stroke
   - ☐ Diabetes
   - ☐ Gall Stones
   - ☐ Chronic Indigestion
   - ☐ Kidney Disease
   - ☐ Kidney Stones
   - ☐ Bladder Disease
   - ☐ Cirrhosis of the Liver
   - ☐ Tuberculosis
   - ☐ Chronic Bronchitis
   - ☐ Emphysema
   - ☐ Hay Fever
   - ☐ Asthma
   - ☐ Stomach Ulcer
   - ☐ Duodenal Ulcer
   - ☐ Diverticulosis
   - ☐ Rectal Polyps
   - ☐ Colon Polyps
   - ☐ Thyroid Condition
   - ☐ Arthritis
   - ☐ Breast Cysts
   - ☐ Gynecological Problems
   - ☐ Hepatitis
   - ☐ Any other serious disease (specify) _____
3. Have you ever had an operation? ☐ Yes ☐ No
   If "yes," specify type and date(s) of operation(s):
4. How **many** x-ray or fluoroscopic **examinations** (GI series, barium enema, etc.) have you **ever** had of:

	0	1-5	6 or More		0	1-5	6 or More
Stomach	☐	☐	☐	Chest	☐	☐	☐
Intestine	☐	☐	☐	Breast	☐	☐	☐
Back	☐	☐	☐	Head/Neck	☐	☐	☐

5. Have you ever been **treated** with radium, x-rays, or radioactive isotopes? ☐ Yes ☐ No
   If "yes," when? _____
   For what disease? _____
   What part of your body? _____
6. How many times have you had colds or flu in the past twelve months? _____

CURRENT PHYSICAL CONDITION:

1. How much exercise do you get (work or play)?
   ☐ None ☐ Slight ☐ Moderate ☐ Heavy
2. On the average, how many hours do you sleep each night?_____
3. On the average, how many times a month do you have insomnia?_____ ☐ None
4. Within the last twelve months, have you noticed:
   a) A lump or thickening in your breast?
   ☐ Yes ☐ No
   b) An unusual discharge from your breast?
   ☐ Yes ☐ No
5. Do you notice pains in your legs when you walk which go away when you rest? ☐ Yes ☐ No
   If "yes," how many years have you had these pains?_____
6. Are you sick at the present time? ☐ Yes ☐ No
   If "yes," with what disease or condition?_____
   _____
   _____

MENSTRUAL AND REPRODUCTIVE HISTORY:

1. How old were you when menstruation began?____
2. What is your current menopausal status?
   ☐ Still regularly menstruating
   ☐ In menopause ☐ Past menopause
3. During your menstrual history:
   a) Are (were) your periods: ☐ Regular ☐ Irregular
   b) What is (was) the usual number of days of flow?_____
4. **If past menopause:**
   a) Was your menopause: ☐ Natural ☐ Artificial
   b) Age when periods stopped completely?____
   c) Did you have excessive bleeding during menopause? ☐ Yes ☐ No
5. Have you ever had or tried to have children?
   ☐ Yes ☐ No
   If "no," skip to question 9.
6. Have you ever had difficulty becoming pregnant?
   ☐ Yes ☐ No
   If "yes," what was the reason?_____
   _____
   _____
7. How many times have you been pregnant?____
   a) Your age at your first pregnancy?____
   b) Your age at your first live birth?____
   c) Number of children born alive?____
   d) Number of stillbirths (carried 5 months or more)?____
   e) Number of miscarriages (carried less than 5 months)?____
8. Were you ever given DES (Diethylstilbestrol) to prevent miscarriage? ☐ Yes ☐ No
   If "yes,"
   a) At what age did you take it?_____
   b) For how many months did you take it?____
9. Birth control methods: Indicate your age when **first used** and number of years of use.

Method Used	Age	Years
Rhythm		
Diaphragm		
Cream/Foam/Jelly		
Tubal Ligation		
Intrauterine Device (IUD)		
Condom (partner)		
Vasectomy (partner)		
NONE OF THE ABOVE ☐		

10. Have you **ever** taken oral contraceptives (birth control pills)? ☐ Yes ☐ No
    If "no," skip to question 11.
    a) Age when you first took them?____
    b) How many years did you take them?____
    c) What brand(s) do (did) you take?_____
    d) If you stopped taking them, what was the reason?_____
    e) Did you have irregular or painful periods when you stopped? ☐ Yes ☐ No
11. Have you **ever** used female hormones (estrogens) other than oral contraceptives? ☐ Yes ☐ No
    a) Why do (did) you take estrogens?
    ☐ Menopausal symptoms ☐ Hysterectomy
    ☐ Bone problems ☐ Cancer
    ☐ Other (specify)_____
    b) Age first took estrogens?_____
    c) For how many years did you take them?____
    d) How did you take them? ☐ Injection ☐ Cream
    ☐ Pill (brand):_____

HABITS:

1. **Whether or not you smoke,** on the average, how many **hours a day** are you exposed to cigarette smoke of others:
   At home____, At work____, In other areas____.
2. Do you now or have you ever smoked cigarettes, at least one a day for one year's time? ☐ Yes ☐ No

Smoking History	Current Smokers	Ex-Smokers
Number smoked a day		
Age began smoking		
Age quit smoking		
Most recent (last) brand		
Years smoked **this** brand		
Total years smoked **filtered** cigarettes		
Total years smoked **non-filtered** cigarettes		
Total years of smoking (filtered + non-filtered)		

3. Current **and** ex-smokers:
   a) Do (did) you inhale? ☐ No, never
   ☐ Slightly ☐ Moderately ☐ Deeply
   b) Fill in the following information for:
   1) The **first** brand smoked regularly; and
   2) The brand of cigarette smoked for the **longest** period of time.

Brand Name	Size	Filter		Menthol		Number Per Day	Years
		Yes	No	Yes	No		
1.							
2.							

DIET:

1. On the average, how many days per week do you eat the following foods? (If less than once a week, but at least twice a month, write 1/2.)

Beef	Raw vegetables
Pork	Carrots
Chicken	Squash/Corn
Liver	Citrus fruits/Juices
Ham	Spaghetti/Macaroni/ White rice
Fish	White bread/Rolls/ Biscuits
Smoked meats	Brown rice/Whole wheat/Barley
Frankfurters/ Sausage	Bran/Corn muffins
Butter	Potatoes
Margarine	Oatmeal/Shredded wheat/Bran cereals
Cheese	Cold (Dry) cereals
Eggs	Ice cream
Green leafy vegetables	Chocolate
Tomatoes	
Cabbage/Broccoli/ Brussels sprouts	

2. How many days a week do you eat the following **fried** foods?

Fried eggs	Fried hamburgers or beef
Fried bacon	Other fried foods
Fried chicken/fish	
French fries	

DO NOT EAT FRIED FOODS ☐

3. Do you eat a vegetarian diet? ☐ Yes ☐ No
   If "yes," what type and for how many years? _____
   _____
4. Has there been a major change in your diet in the last 10 years? ☐ Yes ☐ No
   If "yes," what was the change? _____
   _____
5. a) Do you now or have you ever added artificial sweeteners (saccharin or cyclamates) to coffee, tea, or other drinks or food?
   ☐ Yes, currently ☐ Formerly ☐ Never
   b) If **ever** used artificial sweeteners, indicate amount per day and for how long.
   Packets: No. per day _____ Years _____
   Drops: No. per day _____ Years _____
   Tablets: No. per day _____ Years _____
6. Do you get your drinking water from: ☐ City supply ☐ Private well ☐ Other (specify) _____
7. Do you add any substances to soften your drinking water? ☐ Yes ☐ No
8. How many cups, glasses, or drinks of these beverages do you usually drink a day, and for how many years? (If you no longer drink a listed beverage, or your pattern has changed in the last ten years, indicate previous and current amounts. If less than once a day, but at least three times a week, write 1/2).

Beverages	Currently		Previously	
	Amount	Years	Amount	Years
Whole milk (not skim milk)				
Caffeinated coffee				
Decaffeinated coffee				
Tea				
Diet soda or diet iced tea				
Non-diet colas				
Other non-diet soft drinks				
Beer				
Wine				
Hard liquor				

MEDICATIONS AND VITAMINS:

1. How many times in the last month have you used the following and how long have you used them? (If none, write 0; if used only occasionally, write 1/2.)

Medications and Vitamins	Times	Years
Aspirin, Bufferin, Anacin		
Tylenol		
Vitamin A		
Vitamin C		
Vitamin E		
Multi-Vitamins		
Blood Pressure pills		
Diuretics (water pills)		
Thyroid medications		
Heart medications		
Anti-Acid medications		
Valium		
Librium		
Prescription sleeping pills		
Tagamet (for ulcers)		
Other: _____		
_____		

OCCUPATIONS:

1. What is your current occupation and what are your duties? _____
   _____
   _____ How many years: _____
2. If retired, what was your last occupation? _____
   _____
   _____
   _____ Year retired: _____
3. What other job have you held for the longest period of time? _____
   _____
   _____ How many years: _____
4. What time of day do you start working? _____
   Do you work rotating shifts? ☐ Yes ☐ No
5. How many hours a week do you work on:
   paid jobs _____, volunteer work _____,
   housework _____.
6. In your work or daily life, are (were) you **regularly** exposed to any of the following? If "yes," indicate the number of years exposed.

Exposure to:	Check One		Number of Years
	Yes	No	
Asbestos			
Chemicals/Acids/Solvents			
Coal or Stone Dusts			
Coal Tar/Pitch/Asphalt			
Diesel Engine Exhaust			
Dyes			
Formaldehyde			
Gasoline Exhaust			
Pesticides/Herbicides			
Textile Fibers/Dusts			
Wood Dust			
X-rays/Radioactive Materials			

REMARKS:

MISCELLANEOUS:

1. Where were you born? _____ (city) _____ (state/country)
2. Where were your parents born?
   Father: _____
   Mother: _____
3. Religion: ☐ Protestant ☐ Catholic ☐ Jewish
   ☐ LDS ☐ Other _____ ☐ None
   If Protestant, what denomination? _____
4. Education:
   ☐ 8th Grade or Less ☐ Some College
   ☐ Some High School ☐ College Graduate
   ☐ High School Graduate ☐ Graduate School
   ☐ Vocational/Trade School
5. How many years have you lived in your present neighborhood? _____
6. How many friends or relatives do you feel close to? _____
7. How many times a month do you:
   a) Go to church or temple? _____
   b) Attend club meetings? _____
   c) Participate in group activities? _____
8. What is the most upsetting event that happened to you in about the last five years? _____
   _____
   _____ ☐ None
9. How many people do you take care of in your household? (Include yourself) _____
10. Do you now or have you ever used a **permanent** hair dye? ☐ Yes ☐ No
    If "yes,"
    a) What brand? _____
    b) What color? _____
    c) How often applied? _____
    d) How many years have you used it? _____
11. Do you now or have you ever used mouthwash? ☐ Yes ☐ No
    If "yes,"
    a) What brand? _____
    b) How many times a week is it used? _____
    c) For how many years have you used it? _____