LIFE LINK AMERICAN CANCER SOCIETY®
Give an ounce for prevention

MEN'S SURVEY

INSTRUCTIONS

- Please ask the volunteer for help if you have any questions.
- Print legibly using a blue or black ink pen.
- When entering numbers, enter one per box and stay within the box.
- For the ovals, place a heavy dark mark within the oval or fill in the oval completely.
- If you wish to change an answer, place an "X" through the first mark, and mark the oval for your preferred answer.

Please **PRINT** where applicable.

I K 2 5

CORRECT

a 2 k

INCORRECT

1. What is today's date? Month Day Year

2. What is your full legal name? (Please print)

First ______ Middle Initial

Last ______

3. What is your current state of residence? (please use state abbreviation) State

4. What is your social security number? (do not use your spouse's number)

5. What is your date of birth? Month Day Year

IMPORTANT!

AFTER YOU HAVE COMPLETED THIS QUESTIONNAIRE, PLEASE GIVE IT TO THE VOLUNTEER, WHO WILL IMMEDIATELY PLACE IT INTO AN ENVELOPE TO PROTECT YOUR PRIVACY AND CONFIDENTIALITY.

For Office Use Only:
CPS ID Number:

PLACE BARCODE LABEL HERE

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6. What is your current weight?

Pounds

7. What time did you wake up today? (Round to the nearest hour; mark 12 PM for noon)

- AM
- PM

8. How many hours ago did you have something to eat or drink, other than plain water?

- Less than 2 hours ago
- 2-4 hours ago
- 5-7 hours ago
- 8-11 hours ago
- 12 or more hours ago

9. Are you currently on a special diet that is different from your usual diet?

- No → **(Go to question 11.)**
- Yes

If yes, please mark all that apply:

- Low Fat Diet
- Low Sugar Diet
- Low Salt Diet
- High Fiber Diet
- Vegetarian
- Reduced Calorie Diet
- Other________________

10. How long have you been on this special diet?

- I am not on a special diet
- Less than 1 week
- 1-4 weeks
- More than 4 weeks, but less than 1 year
- 1 or more years

11. Do you currently smoke cigarettes?

- No
- Yes

12. Do you currently smoke cigars or pipes?

- No
- Yes

13. Do you currently use smokeless tobacco products, like chewing tobacco or snuff?

- No
- Yes

14. In the last 24 hours, how many drinks of beer, wine, or liquor have you had?

- zero
- 1 drink
- 2 drinks
- 3 or more drinks

15. Over the last month, on average, how many drinks of beer, wine, or liquor have you had?

- Zero drinks
- 1-3 drinks each month
- 1 drink each week
- 2 - 4 drinks each week
- 5 - 6 drinks each week
- 1 drink each day
- 2 - 3 drinks each day
- 4 or more drinks each day

16. How many hours each week do you walk for exercise (for 20 minutes or more without stopping)?

- Zero hours each week
- Less than 1 hour each week
- One hour each week
- 2 - 3 hours each week
- 4 or more hours each week

17. Over the last month, how many hours each week did you participate in vigorous physical activity (activities that raise your heart rate or make you sweat, such as jogging or running, lap swimming, tennis, bicycling, aerobics, or using an exercise machine). Do not include walking.

- Zero hours each week
- Less than 1 hour each week
- One hour each week
- 2 - 3 hours each week
- 4 or more hours each week

18. When was the last time you participated in 20 minutes or more of vigorous physical activity (activities that raise your heart rate or make you sweat, such as jogging or running, lap swimming, tennis, bicycling, aerobics, or using an exercise machine)? Do not include walking.

- I do not do vigorous physical activity
- Today
- Yesterday
- In the last week
- More than 1 week ago

	When was the last time that you took this?					How many days each week do you take this?			
	Today	Yester-day	In the last week	More than one week ago	Never or rarely	1-3	4-5	6-7	Never or less than once a week
19. For all of the following medications?									
a. Aspirin, Acetylsalicylic Acid, Bufferin, etc.									
b. Ibuprofen, Motrin, Advil, Aleve, Naprosyn, etc.									
c. Acetaminophen, Tylenol, etc.									
d. Cold medicines									
e. Allergy medicines (Allergy shots)									
f. Prescription pain relief medications/ anti-inflammatories (such as Tylenol #3 w/codeine, Hydrocodone, etc.)									
20. For any multivitamins:									
a. Multivitamin (such as Stress-tabs, Theragran, One-a-day, Centrum, etc.)									
21. For the following supplements, not including multivitamins:									
a. Beta Carotene/Vitamin A									
b. Niacin									
c. Vitamin B Complex									
d. Vitamin B12 injections (shots)									
e. Folate or Folic Acid									
f. Vitamin C (Ascorbic Acid)									
g. Vitamin D									
h. Vitamin E (Tocopherol)									
i. Calcium, including Tums									
j. DHEA									
k. Melatonin									
l. Iron									
m. Selenium									

22. Have you taken any other vitamins or supplements in the last 24 hours?

- ◯ No
- ◯ Yes

If yes, please list what other vitamins, dietary, or herbal supplements you have taken in the last 24 hours:

____

____

____

23. Are you currently taking any of the following medications?

	No	Yes
a. Cholesterol-lowering (such as Mevacor, Zocor, Pravachol, Lopid, Lescol, Questran, (lovastatin), etc.)	◯	◯
b. Medications for Heart or Blood Pressure (such as Procardia, Cardizem, Lasix, Lopressor, Tenormin, Vasotec, Zestril, etc.)	◯	◯
c. Fenasteride (Proscar)	◯	◯
d. Viagra	◯	◯
e. Insulin injections for diabetes	◯	◯
f. Oral diabetes medications	◯	◯
g. Oral Steroids (such as Prednisone) or steroid injections	◯	◯
h. Thyroid Medications (such as Synthroid, or Levo thyroxine)	◯	◯
i. Anti-depressant medications (such as Prozac, Zoloft, Paxil, Effexor, Serzone, Elavil, (amitriptyline, nortriptyline), etc.)	◯	◯
j. Blood anticoagulants (such as warfarin, Coumadin)	◯	◯
k. Antibiotics (such as penicillins, sulfa drugs, cyclosporins, tetracycline, etc.)	◯	◯

24. Have you taken any other medications in the last week?

- ◯ No
- ◯ Yes

If yes, please list any other medications that you have taken in the last week:

____

____

____

25. Have you ever been diagnosed with any of the following conditions? If so, when were you first diagnosed?

Condition	Never	Yes, in the last year	Yes, over a year ago
a. Heart attack	◯	◯	◯
b. Diabetes	◯	◯	◯
c. Liver disease or failure	◯	◯	◯
d. Renal (kidney) disease	◯	◯	◯
e. Prostate cancer	◯	◯	◯
f. Colon or rectal cancer	◯	◯	◯
g. Skin cancer, other than melanoma	◯	◯	◯
h. Melanoma skin cancer	◯	◯	◯
i. Other cancer	◯	◯	◯

If other cancer, please specify which type: ______________________________

26. In the last ten years, have you had any medical treatment for cancer, such as surgery, radiation therapy, or chemotherapy? (Do not include screening or detection tests)

- ◯ No
- ◯ Yes

If yes, what was the last year that you had any such treatment? → Year ☐☐☐☐

27. During the last three months, have you been hospitalized for at least 24 hours?

- ◯ No
- ◯ Yes

If yes, what was the reason (were the reasons) that you were hospitalized?

____

____

28. What time is it right now? (Round to the nearest hour; mark 12 PM for noon) ☐☐ ◯ AM ◯ PM

It is important for us to know the time that your blood sample is collected.

Thank you for completing this questionnaire. Please give the questionnaire to the volunteer.

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