

CANCER PREVENTION STUDY



MEN

Dear Cancer Prevention Study Participant,

Thank you for your continued participation in the American Cancer Society's Cancer Prevention Study. The detailed information you provided in 1982 and again in 1992 has made this one of the largest and most valuable studies of cancer cause and prevention in the world.

Almost sixty scientific publications have come from the Cancer Prevention Study. Recent findings include:

- Second-hand smoke increases the risk of both lung cancer and heart disease mortality
- Women taking postmenopausal estrogens have reduced risk of colon cancer mortality
- Women who have had a tubal ligation are at reduced risk of ovarian cancer
- Spontaneous abortion is not linked to increased risk of breast cancer
- Smoking may result in poorer survival for both breast and prostate cancer patients

Please continue to be a part of this important research by completing and returning the attached survey within 10 days. It should take about 20 minutes to complete.

In addition, please take a moment to verify that the information printed at left is your full legal name and correct address and to make corrections if needed. We will use this information to identify cases of cancer through cancer registries and death indexes. As always, all information is kept strictly confidential and is used for medical statistical purposes only.

Thank you again for your continued participation in this important study. What we learn about cancer may help you, your children, and your grandchildren. If you have any questions about the survey, please call us at 1-800-646-7853.

Sincerely,

A handwritten signature in cursive script that reads "Clark W. Heath, Jr." with a small flourish at the end.

Clark W. Heath, Jr., MD
Vice President
Epidemiology and Surveillance Research



Please make sure that the name and address above are your full LEGAL name and current address.

Make any necessary changes on this page.



INSTRUCTIONS

This form is designed to be read by optical scanning equipment, so it is important that you follow these directions:

- Use #2 pencil
- Make no stray marks on the survey
- Erase completely to change a response
- Fill in the box completely with a dark mark

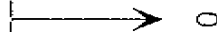
Example:



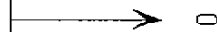
CORRECT

BEFORE TURNING TO THE QUESTIONNAIRE, PLEASE READ THE BOXES BELOW.

If the person whose name appears on this form is deceased, please mark this bubble and **STOP HERE**. Please return the blank questionnaire in the postage-paid envelope.



The answers to the following questions should be provided by the person named on the mailing label. If someone else provides the answers **about that person**, please mark this bubble.



THANK YOU FROM THE EPIDEMIOLOGY STAFF OF THE AMERICAN CANCER SOCIETY!

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MAKE NO MARKS IN THIS AREA



318003

MEDICATIONS

8. Have you, on a regular basis, taken any of the following medications?

CHOLESTEROL-LOWERING *for example: Mevacor, Zocor, Pravachol, Lipid, Lescol, Questran, (lovastatin), etc.*

FOR HEART OR BLOOD PRESSURE:

Calcium blocker *for example: Procardia, Cardizem, Norvasc, Calan, Adalat, Sular, (verapamil, amlodipine), etc.*

Beta blocker *for example: Lopressor, Tenormin, Inderal, (atenolol, metoprolol), etc.*

ACE inhibitor *for example: Vasotec, Zestril, Capoten, Prinivil, Lotensin, Accupril, Monopril, (captopril), etc.*

Diuretic *for example: Lasix, Lozol, (triamterene, HCTZ, furosemide, thiazides), etc.*

Other *(mark here if unsure of heart or blood pressure medication category)*

FOR URINARY SYMPTOMS:

Finasteride *for example: Proscar*

Alpha blocker *for example: Hytrin, Cardura, (doxazosin, terazosin), etc.*

FOR STOMACH ACID:

H2 blocker *for example: Zantac, Pepcid, Tagamet, Axid, (ranitidine, cimetidine), etc.*

Other acid-suppression capsules/tablets *for example: Prilosec, Cytotec, Prevacid, etc.*

Other antacids *for example: Tums, Roloids, Maalox, Mylanta, etc.*

ANTIDEPRESSANT *for example: Prozac, Zoloft, Paxil, Effexor, Serzone, Elavil, (amitriptyline, nortriptyline), etc.*

INSULIN INJECTIONS

FIBER LAXATIVES *for example: Metamucil, Citrucel, Fibercon, Fiberall, Konsyl, (psyllium), etc.*

NON-FIBER LAXATIVES *for example: Ex-Lax, Correctol, Dulcolax, Senokot, (milk of magnesia), etc.*

No	Yes, but NOT currently	Yes, currently
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

HEALTH CARE COVERAGE

9. What type of health care coverage do you currently use to pay for **most** of your medical care? *(mark all that apply)*

- Medicare plus other insurance
- Medicare by itself
- Your employer
- Someone else's employer
- A plan that you or someone else buys on your own
- Medicaid or Medical Assistance
- The military, CHAMPUS, or the VA
- Some other source
- Don't have health care coverage *(go to question 12)*

10. Does your current health care plan **require** you to select a certain primary care doctor or a certain clinic for all your routine care?

- Yes
- No
- Don't know

11. If you need treatment by a specialist, does your current plan **require** a referral or prior approval?

- Yes
- No
- Don't know



MEDICATIONS / VITAMINS

12. 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="radio"/>	<input type="text"/> <input type="text"/> → <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Regular or extra-strength aspirin (163 mg. or more) <i>for example: Bufferin, Anacin, Bayer, Excedrin, Ecotrin, etc.</i>	<input type="radio"/>	<input type="text"/> <input type="text"/> → <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Ibuprofen <i>for example: Motrin, Advil, Nuprin, Mediprin, etc.</i>	<input type="radio"/>	<input type="text"/> <input type="text"/> → <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Acetaminophen <i>for example: Tylenol, Phenaphen, etc.</i>	<input type="radio"/>	<input type="text"/> <input type="text"/> → <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>
Other anti-inflammatory analgesics <i>for example: Naprosyn, Anaprox, Aleve, Voltaren, Feldene, Toradol, Indocin, etc.</i>	<input type="radio"/>	<input type="text"/> <input type="text"/> → <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>

13. Do you currently take a multi-vitamin? (for example: Stress-tabs, Theragran, One-a-day, Centrum, etc.) (Please report additional individual vitamins in question 14)

- No, or less than once a week (go to question 14)
- Yes, at least once a week → How many do you take per week?
 - 1-3
 - 4-6
 - 7-9
 - 10 or more

14. Not counting multi-vitamins, do you regularly take any of the following supplements, individually or in combination? (Mark either YES or NO for each.)

	Amount per day							
Beta Carotene	<input type="radio"/> No	<input type="radio"/> Yes →	<input type="radio"/> Less than 8,000 IU	<input type="radio"/> 8,000 to 12,000 IU	<input type="radio"/> 13,000 to 22,000 IU	<input type="radio"/> 23,000 IU or more	<input type="radio"/> Don't know	
Vitamin A	<input type="radio"/> No	<input type="radio"/> Yes →	<input type="radio"/> Less than 8,000 IU	<input type="radio"/> 8,000 to 12,000 IU	<input type="radio"/> 13,000 to 22,000 IU	<input type="radio"/> 23,000 IU or more	<input type="radio"/> Don't know	
Vitamin E	<input type="radio"/> No	<input type="radio"/> Yes →	<input type="radio"/> Less than 100 IU	<input type="radio"/> 100 to 250 IU	<input type="radio"/> 300 to 500 IU	<input type="radio"/> 600 IU or more	<input type="radio"/> Don't know	
Vitamin C	<input type="radio"/> No	<input type="radio"/> Yes →	<input type="radio"/> Less than 400 mg	<input type="radio"/> 400 to 700 mg	<input type="radio"/> 750 to 1,250 mg	<input type="radio"/> 1,300 mg or more	<input type="radio"/> Don't know	
Folic Acid	<input type="radio"/> No	<input type="radio"/> Yes →	<input type="radio"/> Less than 100 mcg	<input type="radio"/> 100 to 300 mcg	<input type="radio"/> 301 to 500 mcg	<input type="radio"/> 501 mcg or more	<input type="radio"/> Don't know	
Calcium	<input type="radio"/> No	<input type="radio"/> Yes →	<input type="radio"/> Less than 400 mg	<input type="radio"/> 400 to 900 mg	<input type="radio"/> 901 to 1,300 mg	<input type="radio"/> 1,301 mg or more	<input type="radio"/> Don't know	

(If you take Tums for calcium, count each tablet as 250 mg.)

SCREENING

15. **During the last 2 years**, have you been to the doctor's office/clinic? *(mark all that apply)*

- No
- Yes, for symptoms
- Yes, for routine check-up

16. **During the last 2 years**, have you had a rectal exam? *(mark all that apply)*

- No
- Yes, for symptoms
- Yes, for routine check-up

17. Have you **ever** had a sigmoidoscopy or colonoscopy of the bowel?

- No *(go to question 18)*
- Don't know *(go to question 18)*
- Yes

→ a) How many times have you had a sigmoidoscopy or colonoscopy?

- 1
- 2-3
- 4 or more

b) When was your **most recent** one?

- Before 1990
- 1990-1991
- 1992-1993
- 1994-1995
- 1996-1997
- 1998

c) What was the reason for your **most recent** one? *(mark all that apply)*

- Visible blood in stool
- Positive test for fecal occult blood
- Symptoms (pain, diarrhea, other)
- Followup of previous polyp or cancer
- Family history of colon cancer
- Screening (no symptoms)
- Don't know

18. **During the last 2 years, on average**, how frequently did you feel constipated to the point of having to take something, such as a laxative, enema, or prunes?

- Never
- Less than once a month
- 1-3 times a month
- Once a week or more

19. Have you **ever** had a PSA blood test for prostate cancer screening?

- No *(go to question 20)*
- Don't know *(go to question 20)*
- Yes

→ a) When was your **first** PSA blood test?

- Before 1992
- 1992-1993
- 1994-1995
- 1996-1997
- 1998

b) Have you **ever** had an elevated PSA?

- No
- Yes
- Don't know

c) When was your **most recent** PSA?

- Before 1992
- 1992-1993
- 1994-1995
- 1996-1997
- 1998

d) Was your **most recent** PSA elevated?

- No
- Yes
- Don't know

20. Have you **ever** had a prostate biopsy or rectal ultrasound for prostate examination?

- No
- Yes
- Don't know

21. During the past month, how often have you:

Amount of time experienced symptoms

had a sensation of not-emptying your bladder completely after you finished urinating?

had to urinate again in less than two hours after you finished urinating?

found you stopped and started again several times when you urinated?

found it difficult to postpone urination?

had a weak urinary stream?

had to push or strain to begin urinating?

Not at all	Some-times	Less than half the time	About half the time	Most of the time	Almost always
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

22. On a typical night, during the past month, how many times did you get up to urinate from the time you went to bed until the time you got up in the morning?

- None 1 time 2 times 3 times 4 times 5+ times

SMOKING / ALCOHOL

23. Do you smoke cigarettes now?

I have **never** smoked cigarettes regularly. (go to question 24)

No, I no longer smoke cigarettes.

↳ When did you quit the last time?

- Less than 1 year ago
 1-2 years ago
 3-5 years ago
 more than 5 years ago

Yes, I currently smoke cigarettes.

↳ How many cigarettes do you smoke per day?

- 1-9 20
 10 21 or more
 11-19

24. On average, how frequently did you drink any alcoholic beverage (beer, wine, or liquor) in the last year?

- Never or less than 1 day per month 2-3 days per week
 1-3 days per month 4-5 days per week
 1 day per week 6-7 days per week

25. On days that you drink, how many drinks of alcohol (beer, wine, or liquor) do you have on average?

- I don't drink alcohol 4 drinks
 1 drink 5 drinks
 2 drinks 6 or more drinks
 3 drinks



FAMILY HISTORY

26. Please mark which of your following **BIOLOGICAL** relatives listed (living or dead) has ever had any of these cancers. (don't count half-siblings) Include relative's age at diagnosis, if known:

Prostate cancer:

<input type="radio"/> Father	Relative's age at diagnosis	<table border="1"><tr><td></td><td></td></tr></table>		
<input type="radio"/> One brother		<table border="1"><tr><td></td><td></td></tr></table>		
<input type="radio"/> Additional brother		<table border="1"><tr><td></td><td></td></tr></table>		
<input type="radio"/> Additional brother		<table border="1"><tr><td></td><td></td></tr></table>		
<input type="radio"/> Son		<table border="1"><tr><td></td><td></td></tr></table>		
<input type="radio"/> None of the above				

Breast cancer:

<input type="radio"/> Mother	Relative's age at diagnosis	<table border="1"><tr><td></td><td></td></tr></table>		
<input type="radio"/> One sister		<table border="1"><tr><td></td><td></td></tr></table>		
<input type="radio"/> Additional sister		<table border="1"><tr><td></td><td></td></tr></table>		
<input type="radio"/> Additional sister		<table border="1"><tr><td></td><td></td></tr></table>		
<input type="radio"/> Daughter		<table border="1"><tr><td></td><td></td></tr></table>		
<input type="radio"/> None of the above				

Colon or Rectal cancer:

<input type="radio"/> Mother	<table border="1"><tr><td></td><td></td></tr></table>		
<input type="radio"/> Father	<table border="1"><tr><td></td><td></td></tr></table>		
<input type="radio"/> One sister	<table border="1"><tr><td></td><td></td></tr></table>		
<input type="radio"/> Additional sister	<table border="1"><tr><td></td><td></td></tr></table>		
<input type="radio"/> One brother	<table border="1"><tr><td></td><td></td></tr></table>		
<input type="radio"/> Additional brother	<table border="1"><tr><td></td><td></td></tr></table>		
<input type="radio"/> Daughter	<table border="1"><tr><td></td><td></td></tr></table>		
<input type="radio"/> Son	<table border="1"><tr><td></td><td></td></tr></table>		
<input type="radio"/> None of the above			

Ovarian cancer:

<input type="radio"/> Mother	<table border="1"><tr><td></td><td></td></tr></table>		
<input type="radio"/> One sister	<table border="1"><tr><td></td><td></td></tr></table>		
<input type="radio"/> Additional sister	<table border="1"><tr><td></td><td></td></tr></table>		
<input type="radio"/> Daughter	<table border="1"><tr><td></td><td></td></tr></table>		
<input type="radio"/> None of the above			

Pancreatic cancer:

<input type="radio"/> Mother	<table border="1"><tr><td></td><td></td></tr></table>		
<input type="radio"/> Father	<table border="1"><tr><td></td><td></td></tr></table>		
<input type="radio"/> Sister	<table border="1"><tr><td></td><td></td></tr></table>		
<input type="radio"/> Brother	<table border="1"><tr><td></td><td></td></tr></table>		
<input type="radio"/> None of the above			

WAIST SIZE

27. Please use a tape measure to measure your waist just above the navel. (Try to record to the nearest 1/4 inch.)

Inches	<input type="radio"/> 1/4		
<table border="1"><tr><td></td><td></td></tr></table>			<input type="radio"/> 1/2
	<input type="radio"/> 3/4		

- For an accurate measurement:
- Take measurement while standing
 - Avoid measuring over bulky clothing
 - Measure from the zero end of the tape

ADDITIONAL INFORMATION

28. Please indicate the name of someone at a different permanent address to whom we might write if we are unable to contact you in the future. (please print)

Name: _____

Address: _____

Street

City State Zip Code

Thank you for your quick response. Please return questionnaire in the postage-paid envelope provided to: **CANCER PREVENTION STUDY, PO BOX 1208, TUSTIN, CA 92681-9954**