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,

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

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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 answer about that person, please mark this bubble.

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

1. What is your current marital status?
   - ○ Married
   - ○ Divorced
   - ○ Widowed
   - ○ Never married
   - ○ Separated

2. Is this your correct date of birth?
   - ○ Yes, this is my birthday
   - ○ No, my birthday is:
   - Month:  
   - Day:  
   - Year:  

3. What is your current work status?
   - (mark all that apply)
   - ○ Work full-time
   - ○ Work part-time
   - ○ Volunteer work
   - ○ Homemaker
   - ○ Retired
   - ○ Disabled

**MEDICAL**

6. Has a physician ever told you that you had any of the following?
   (If not, mark No; if yes, mark year first diagnosed.)
   - ○ Fibrocystic/other benign breast disease
   - ○ Breast cancer
   - ○ Cancer of the cervix
   - ○ Cancer of the uterus or endometrium
   - ○ Cancer of the ovary
   - ○ Lung or bronchial cancer
   - ○ Benign polyp of the colon or rectum
   - ○ Colon or rectal cancer
   - ○ Skin cancer (non-melanoma)
   - ○ Melanoma
   - ○ Bladder cancer
   - ○ Other cancer
     (Specify other cancer: )

7. Has a physician ever told you that you had any of the following?
   (If not, mark No; if yes, mark year first diagnosed.)
   - ○ High cholesterol (diagnosed by your physician)
   - ○ High blood pressure (except during pregnancy)
   - ○ Heart attack, angina, or coronary artery disease
   - ○ Coronary bypass or angioplasty
   - ○ Stroke or transient ischemic attack (TIA)
   - ○ Diabetes (except during pregnancy)
   - ○ Emphysema or chronic bronchitis
   - ○ Gallbladder problems, gallbladder not removed
   - ○ Gallbladder problems, gallbladder removed
   - ○ Osteoporosis
   - ○ Hip fracture
   - ○ Wrist fracture

**BODY WEIGHT / ACTIVITY**

4. What is your current weight?  
   Pounds:  

5. During the past year, have you engaged in any of the following activities? (If not, mark No; if yes, mark hours per week.)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Hours per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Walking</td>
<td></td>
</tr>
<tr>
<td>Jogging/running</td>
<td></td>
</tr>
<tr>
<td>Lap swimming</td>
<td></td>
</tr>
<tr>
<td>Tennis or racquetball</td>
<td></td>
</tr>
<tr>
<td>Bicycling/exercise machines</td>
<td></td>
</tr>
<tr>
<td>Aerobics/calisthenics</td>
<td></td>
</tr>
<tr>
<td>Dancing</td>
<td></td>
</tr>
<tr>
<td>Gardening, mowing, planting, etc.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Yes - Hours per week</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 1</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Yes - Year first diagnosed</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
</tr>
</tbody>
</table>
**Cancer Prevention Study**

### MEDICATIONS

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

<table>
<thead>
<tr>
<th>CHOLESTEROL-LOWERING</th>
<th>for example: Mevacor, Zocor, Pravachol; Lopid, Lescol, Questran, (lovastatin), etc.</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOR HEART OR BLOOD PRESSURE:</td>
<td></td>
</tr>
<tr>
<td>Calcium blocker</td>
<td>for example: Procardia, Cardizem, Norvasc, Calan, Amlodipine, Sular, (verapamil, amlopidine), etc.</td>
</tr>
<tr>
<td>Beta blocker</td>
<td>for example: Lopressor, Tenormin, Inderal, atenolol, metoprolol, etc.</td>
</tr>
<tr>
<td>ACE Inhibitor</td>
<td>for example: Vasotec, Zestril, Capoten, Printil, Intensin, Accupril, Monopril, captopril, etc.</td>
</tr>
<tr>
<td>Diuretic</td>
<td>for example: Lasik, Lozol, (triamterene, HCTZ, furosemide, thiazides), etc.</td>
</tr>
<tr>
<td>Other</td>
<td>(mark here if unsure of heart or blood pressure medication category)</td>
</tr>
<tr>
<td>FOR STOMACH ACID:</td>
<td></td>
</tr>
<tr>
<td>H2 Blocker</td>
<td>for example: Zantac, Pepcid, Tegamet, Axid, (ranitidine, cimetidine), etc.</td>
</tr>
<tr>
<td>Other acid-suppression</td>
<td>for example: Prilosec, Cytotec, Provacid, etc.</td>
</tr>
<tr>
<td>Omeprazole/tablet</td>
<td>for example: Tums, Rolaid, Maalox, Mylanta, etc.</td>
</tr>
<tr>
<td>Other antacids</td>
<td>for example: Prozac, Zoloft, Paxil, Effexor, Serzone, Elavil, (amitriptyline, norriptyline), etc.</td>
</tr>
<tr>
<td>INSULIN INJECTIONS</td>
<td></td>
</tr>
<tr>
<td>FIBER LAXATIVES</td>
<td>for example: Metamucil, Citrucel, Fibercon, Fiberall, Konsyl, (psyllium), etc.</td>
</tr>
<tr>
<td>NON-FIBER LAXATIVES</td>
<td>for example: Ex-Lax, Correctol, Dulcolax, Sanokot, (milk of magnesia), etc.</td>
</tr>
<tr>
<td>TAMOXIFEN</td>
<td>for example: Nolvadex, etc.</td>
</tr>
</tbody>
</table>

### 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
12. During the past year, on average, how frequently have you taken the following?

<table>
<thead>
<tr>
<th></th>
<th>Never, or less than once a month</th>
<th>At least once a month</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Aspirin</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baby or low-dose aspirin (162 mg. or less)</td>
<td>○</td>
<td></td>
</tr>
<tr>
<td>Regular or extra-strength aspirin (163 mg. or more) for example: Bufferin, Anacin, Bayer, Excedrin, Ecotrin, etc.</td>
<td>○</td>
<td></td>
</tr>
<tr>
<td><strong>Ibuprofen</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>for example: Motrin, Advil, Nuprin, Mediprin, etc.</td>
<td>○</td>
<td></td>
</tr>
<tr>
<td><strong>Acetaminophen</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>for example: Tylenol, Phenaphen, etc.</td>
<td>○</td>
<td></td>
</tr>
<tr>
<td><strong>Other anti-inflammatory analgesics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>for example: Naprosyn, Anaprox, Aleve, Voltaren, Feldene, Toradol, Indocin, etc.</td>
<td>○</td>
<td></td>
</tr>
</tbody>
</table>

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
  - 7-9
  - 4-6
  - 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.)

<table>
<thead>
<tr>
<th>Vitamin</th>
<th>No</th>
<th>Yes</th>
<th>Amount per day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beta Carotene</td>
<td></td>
<td></td>
<td>Less than 8,000 IU</td>
</tr>
<tr>
<td>Vitamin A</td>
<td></td>
<td></td>
<td>Less than 8,000 IU</td>
</tr>
<tr>
<td>Vitamin E</td>
<td></td>
<td></td>
<td>Less than 100 IU</td>
</tr>
<tr>
<td>Vitamin C</td>
<td></td>
<td></td>
<td>Less than 400 mg</td>
</tr>
<tr>
<td>Folic Acid</td>
<td></td>
<td></td>
<td>Less than 400 mg</td>
</tr>
<tr>
<td>Calcium</td>
<td></td>
<td></td>
<td>Less than 400 mg</td>
</tr>
</tbody>
</table>

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

   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 mammogram (an x-ray of the breasts)?
   - No *(go to question 20)*
   - Don’t know *(go to question 20)*
   - Yes
   
   Mark each year in which you had a mammogram: *(mark all that apply)*
   - Before 1992
   - 1992
   - 1993
   - 1994

20. Have you had surgery to remove your uterus? **Age**
   - No
   - Yes
   - Don’t know

21. Have you had surgery to remove one or both ovaries? *(If both, please list age most recent ovary removed)*
   - No
   - Yes *(one ovary removed)*
   - Yes *(both ovaries removed)*
   - Yes *(don’t know how many)*
   - Don’t know

22. Have your menstrual periods stopped permanently?
   - Yes, I no longer have any bleeding or menstrual periods
   - Yes, I had menopause, but now I have some bleeding because I am taking hormones
   - No, my menstrual periods have not stopped *(go to question 23)*
   - Not sure *(go to question 23)*
   
   a) How old were you when your periods stopped? **Age**
   b) For what reason did your periods stop?
      - Natural menopause
      - Surgical menopause
      - Radiation/chemotherapy
23. Have you ever used female hormones (other than oral contraceptives) for relief of menopausal symptoms or prevention of diseases such as bone loss?
   - No (go to question 25)
   - Yes

   a) How old were you when you started taking female hormones (other than oral contraceptives)?

   b) How many years, in total, have you used each of the following types of female hormones? (mark all that apply) - (If less than 1 year, put 00)
   - Estrogen pills ALONE (e.g., Premarin, Estrace)
   - Estrogen pills (e.g., Premarin) AND progesterone pills (e.g., Provera)
   - Estrogen and progesterone together IN ONE PILL (e.g., Prempro)
   - Patch or vaginal estrogen

24. Are you currently taking female hormones (other than oral contraceptives)?
   - No (go to question 25)
   - Yes

   a) What types of female hormones do you use now? (mark all that you currently use)
   - Estrogen pills (e.g., Premarin, Estrace)
   - Progesterone pills (e.g., Provera)
   - Estrogen and progesterone together in one pill (e.g., Prempro)
   - Patch estrogen
   - Vaginal estrogen

   b) How long have you been using the type, or exact combination of types, that you use now?
   - Less than 1 year
   - 1-2 years
   - 3-5 years
   - 6 or more years

25. When did you have your most recent pap smear?
   - Within the last year
   - 1-3 years ago
   - 4-5 years ago
   - 6 or more years ago
   - Don't know
   - Never had one

26. Do you smoke cigarettes now?
   - I have never smoked cigarettes regularly. (go to question 27)
   - 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
      - 10
      - 11-19
      - 20
      - 21 or more

27. 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
   - 1-3 days per month
   - 4-5 days per week
   - 1 day per week
   - 6-7 days per week

28. On days that you drink, how many drinks of alcohol (beer, wine, or liquor) do you have on average?
   - I don't drink alcohol
   - 1 drink
   - 2 drinks
   - 3 drinks
   - 4 drinks
   - 5 drinks
   - 6 or more drinks
   - 3 drinks
## FAMILY HISTORY

29. 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:

<table>
<thead>
<tr>
<th>Breast cancer:</th>
<th>Relative's age at diagnosis</th>
<th>Prostate cancer:</th>
<th>Relative's age at diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
<td>Father</td>
<td></td>
</tr>
<tr>
<td>One sister</td>
<td></td>
<td>One brother</td>
<td></td>
</tr>
<tr>
<td>Additional sister</td>
<td></td>
<td>Additional brother</td>
<td></td>
</tr>
<tr>
<td>Additional sister</td>
<td></td>
<td>Additional brother</td>
<td></td>
</tr>
<tr>
<td>Daughter</td>
<td></td>
<td>Son</td>
<td></td>
</tr>
<tr>
<td>None of the above</td>
<td></td>
<td>None of the above</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ovarian cancer:</th>
<th>Relative's age at diagnosis</th>
<th>Colon or Rectal cancer:</th>
<th>Relative's age at diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
<td>Mother</td>
<td></td>
</tr>
<tr>
<td>One sister</td>
<td></td>
<td>One sister</td>
<td></td>
</tr>
<tr>
<td>Additional sister</td>
<td></td>
<td>Additional sister</td>
<td></td>
</tr>
<tr>
<td>Daughter</td>
<td></td>
<td>One brother</td>
<td></td>
</tr>
<tr>
<td>None of the above</td>
<td></td>
<td>Additional brother</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pancreatic cancer:</th>
<th>Relative's age at diagnosis</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Father</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sister</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brother</td>
<td></td>
<td></td>
</tr>
<tr>
<td>None of the above</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## WAIST SIZE

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

```
Inches
   ○  1/4
   ○  1/2
   ○  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

31. What is your maiden name? (please print) [Blank line]

32. 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: [Blank line]
Address: [Blank line]
Street: [Blank line]
City: [Blank line] State: [Blank line] Zip Code: [Blank line]

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