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CANCER PREVENTION STUDY

AMERICAN CANCER SOCIETY

WOMEN

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

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!

MAKE NO MARKS IN THIS AREA

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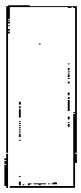
DEMOGRAPHIC

1. What is your **current** marital status?

- ○ Married
- ○ Widowed
- ○ Separated
- ○ Divorced
- ○ Never married

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

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.)*

	No	Yes - Hours per week: Less than 1	1	2-3	4 or more
Walking	○	○	○	○	○
Jogging/running	○	○	○	○	○
Lap swimming	○	○	○	○	○
Tennis or racquetball	○	○	○	○	○
Bicycling/exercise machines	○	○	○	○	○
Aerobics/calisthenics	○	○	○	○	○
Dancing	○	○	○	○	○
Gardening, mowing, planting, etc.	○	○	○	○	○

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.)*

	No	Yes - Year first diagnosed: Before 1992	1992-1993	1994-1995	1996 or after
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.)*

	No	Yes - Year first diagnosed: Before 1992	1992-1993	1994-1995	1996 or after
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	○	○	○	○	○

MEDICATIONS

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

		No	Yes, but NOT currently	Yes, currently
CHOLESTEROL-LOWERING	*for example:* Mevacor, Zocor, Pravachol, Lopid, 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 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, Rolaids, 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.	○	○	○
TAMOXIFEN	*for example:* Nolvadex, etc.	○	○	○

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

MAKE NO MARKS IN THIS AREA

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	At least once a month: Pills per day
Aspirin				
Baby or low-dose aspirin (162 mg. or less)		○	□□ →	□□
Regular or extra-strength aspirin (163 mg. or more)	*for example:* Bufferin, Anacin, Bayer, Excedrin, Ecotrin, etc.	○	□□ →	□□
Ibuprofen	*for example:* Motrin, Advil, Nuprin, Mediprin, etc.	○	□□ →	□□
Acetaminophen	*for example:* Tylenol, Phenaphen, etc.	○	□□ →	□□
Other anti-inflammatory analgesics	*for example:* Naprosyn, Anaprox, Aleve, Voltaren, Feldene, Toradol, Indocin, etc.	○	□□ →	□□

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.)***

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

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

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MAKE NO MARKS IN THIS AREA

SCREENING / WOMEN'S HEALTH ISSUES

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 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
- ○ 1995
- ○ 1996
- ○ 1997
- ○ 1998

20. Have you had surgery to remove your uterus?

- ○ No
- ○ Yes → Age ☐☐
- ○ 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

→ Age ☐☐

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)? Age ☐☐

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) ☐☐ Years
- ○ Estrogen pills (e.g., Premarin) **AND** progesterone pills (e.g., Provera) ☐☐ Years
- ○ Estrogen and progesterone together **IN ONE PILL** (e.g., Prempro) ☐☐ Years
- ○ Patch or vaginal estrogen ☐☐ Years

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

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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

SMOKING / ALCOHOL

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
- ○ 1 day per week
- ○ 2-3 days per week
- ○ 4-5 days 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

MAKE NO MARKS IN THIS AREA

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:**

Breast cancer:
- ○ Mother — Relative's age at diagnosis: ☐☐
- ○ One sister — ☐☐
- ○ Additional sister — ☐☐
- ○ Additional sister — ☐☐
- ○ Daughter — ☐☐
- ○ **None of the above**

Prostate cancer:
- ○ Father — Relative's age at diagnosis: ☐☐
- ○ One brother — ☐☐
- ○ Additional brother — ☐☐
- ○ Additional brother — ☐☐
- ○ Son — ☐☐
- ○ **None of the above**

Ovarian cancer:
- ○ Mother — ☐☐
- ○ One sister — ☐☐
- ○ Additional sister — ☐☐
- ○ Daughter — ☐☐
- ○ **None of the above**

Colon or Rectal cancer:
- ○ Mother — ☐☐
- ○ Father — ☐☐
- ○ One sister — ☐☐
- ○ Additional sister — ☐☐
- ○ One brother — ☐☐
- ○ Additional brother — ☐☐
- ○ Daughter — ☐☐
- ○ Son — ☐☐
- ○ **None of the above**

Pancreatic cancer:
- ○ Mother — ☐☐
- ○ Father — ☐☐
- ○ Sister — ☐☐
- ○ Brother — ☐☐
- ○ **None of the above**

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)***

_____

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: _____

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