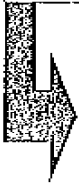


# CANCER PREVENTION STUDY



# MEN

If this is not your full LEGAL name and mailing address, please make changes on this page.



Dear Cancer Prevention Study Participant,

Thank you for your continued participation in the American Cancer Society's Cancer Prevention Study. Because of you and others like you, we have learned a great deal about factors that may cause or prevent cancer.

The attached **very brief** questionnaire asks only for the most important information necessary for continuing our research. We have made it as short as possible in the hope that you will take a few minutes to complete the form.

In addition, please take a moment to verify that the information printed above is your full legal name and correct mailing address. 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.

Please continue to be a part of this important research. Your prompt reply will help us provide answers to the many unresolved questions concerning lifestyle and cancer.

With many thanks,

Michael J. Thun, MD  
Vice President  
Epidemiology and Surveillance Research

## 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.





### INSTRUCTIONS

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

- USE NO. 2 PENCIL ONLY
- Fill in the bubble completely with a dark mark
- Erase completely to change a response
- Make no stray marks on the survey

#### Example:



**WE APPRECIATE YOU TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE!**

MAKE NO MARKS IN THIS AREA

■ ■ ○ ■ ■ ■ ○ ○ ■ ■ ■ ○ ○ ○ ○ ○ ○

5947



1. Is this your correct date of birth?

Yes, this is my birthday

\_\_\_\_\_

No, my birthday is:

\_\_\_\_\_

Month    Day    Year

□□    □□    □□

2. What is your state of birth? *(please print)*

\_\_\_\_\_

3. What is your current weight?      Pounds

□□□□

4. Do you smoke cigarettes now?

No       Yes

5. During the past year, have you engaged in any of the following activities?  
*(If not, leave blank. If yes, mark hours per week.)*

|                                   | YES - Hours per week  |                       |                       |                       |
|-----------------------------------|-----------------------|-----------------------|-----------------------|-----------------------|
|                                   | Less than 1           | 1                     | 2-3                   | 4 or more             |
| Walking                           | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Jogging/running                   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Lap swimming                      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Tennis or racquetball             | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Bicycling/exercise machines       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Aerobics/calisthenics             | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Dancing                           | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Gardening, mowing, planting, etc. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

6. Has a physician ever told you that you had any of the following cancers?  
*(If not, leave blank. If yes, mark Yes and year first diagnosed.)*

|  | YES                   | Year first diagnosed  |                       |                       |                       |
|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
|  |                       | Before 1992           | 1992-1993             | 1994-1995             | 1996 or after         |
| Prostate cancer                                | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Lung or bronchial cancer                       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Colon or rectal cancer                         | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Melanoma                                       | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Bladder cancer                                 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Other cancer<br><i>(Specify other cancer:)</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

\_\_\_\_\_

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

No     Don't know     Yes

→ a. When was your most recent PSA blood test?

Before 1992

1992 - 1993

1994 - 1995

1996 - 1997

1998 - 1999

b. Was your most recent PSA elevated?

No     Yes     Don't know





8. 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:**

- Father
- One brother
- Additional brother
- Additional brother
- Son
- None of the above

Relative's age at diagnosis

|  |  |
|--|--|
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Colon or Rectal cancer:**

- Mother
- Father
- One sister
- Additional sister
- One brother
- Additional brother
- Daughter
- Son
- None of the above

Relative's age at diagnosis

|  |  |
|--|--|
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Breast cancer:**

- Mother
- One sister
- Additional sister
- Additional sister
- Daughter
- None of the above

Relative's age at diagnosis

|  |  |
|--|--|
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

9. 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**