

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

Dear Cancer Prevention Study Participant,

This year marks the 19th anniversary of your participation in the Cancer Prevention Study. As always, thank you for your continuing support of this research. Your willingness to carefully complete these questionnaires has made this one of the most valuable studies of cancer cause and prevention in the world.

This year, the questionnaire addresses some new topics by including sun exposure, herbal supplement use, and limitations in daily activity. These new questions allow us to broaden the information you have already given us on lifestyle exposures. In addition, we are asking questions on other topics such as exercise, medications, vitamin use, and medical history in an attempt to update the information you have provided to us in the past.

Please continue to be a part of this important study by completing and returning the attached questionnaire within 10 days. In addition, please take a moment to verify that the information printed above is your full legal name and correct address and to make corrections if needed. We will use this information to verify or 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 research. We value your contribution. If you have any questions about the survey, please call us at 1-800-646-7853.

Sincerely,



Michael J. Thun, M.D.

Vice President

Epidemiology and Surveillance Research

PLEASE BEGIN HERE

1. Is this your correct date of birth?

Yes, this is my birthday →

Month Day Year

No, my birthday is:

2. Is this your correct state of birth?

Yes, this is my birth state →

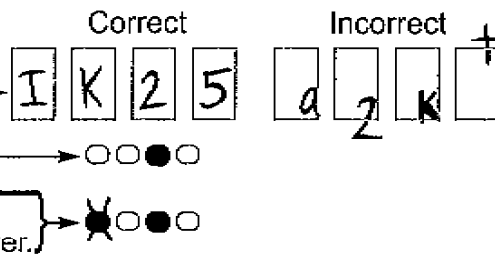
No, my birth state is:

INSTRUCTIONS:

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

- Print legibly using a blue or black ink pen.
- Do not use pencil or felt tip markers.
- When entering letters or numbers, enter one per box and stay within the confines of the box.
- Fill in the ovals completely with a dark mark.
- If you wish to change an answer, place an "X" through the first mark, and mark the oval for your preferred answer.

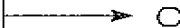
EXAMPLES:



Please **PRINT** where applicable.

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



GENERAL

3. What is your **current** marital status?
- Married Divorced
 Widowed Never married
 Separated
4. What is your **current** living arrangement?
- Alone Assisted living
 With spouse or partner Nursing home
 With other family Other
5. What is your **current** work status?
- Retired Volunteer
 Work full-time Disabled
 Work part-time

6. What is your **current** weight?

Pounds

7. Do you **currently** smoke cigarettes?

- No
 Yes

How many per day?

1-4 cigarettes 25-34
 5-14 35-44
 15-24 45 or more

8. In general, would you say your health is:

- Excellent Fair
 Very Good Poor
 Good

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** that you select a certain primary care doctor from a list or select 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

14. Has a physician ever told you that you had any of the following conditions? (Mark **yes** and **year of diagnosis** for each illness you have had diagnosed. Leave blank for **no**.)

	Mark here for yes ↓	Year first diagnosed		
		Before October 1999	October 1999 - September 2001	After September 2001
Diabetes mellitus	Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Elevated cholesterol	Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High blood pressure	Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Myocardial infarction (heart attack)	Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hospitalized for MI? →	Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Angina pectoris	Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Coronary bypass or angioplasty	Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Stroke (CVA)	Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
TIA (Transient ischemic attack)	Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Carotid surgery (Endarterectomy)	Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Parkinson's Disease	Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Emphysema or chronic bronchitis	Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Osteoporosis	Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Vertebral fracture, x-ray confirmed	Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hip replacement	Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hip fracture	Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wrist or Colles' fracture	Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Osteoarthritis	Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Rheumatoid arthritis	Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ulcerative colitis/Crohn's Disease	Y	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

SCREENING

15. A **colonoscopy** examines the entire colon and rectum. The day before the exam you drink a gallon of salty tasting liquid to cleanse the colon. During the exam you are given medication in an arm vein to make you sleepy. Usually someone has to drive you home.

Have you ever had a colonoscopy?

- No
- Yes → Please state the **age** and **reason** for your first and most recent colonoscopy.

	Age	Reason
First colonoscopy	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input type="radio"/> For routine exam <input type="radio"/> For symptoms
Most recent colonoscopy	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input type="radio"/> For routine exam <input type="radio"/> For symptoms

16. A **sigmoidoscopy** examines the lower part of the colon and rectum with a flexible scope. It is done after an enema while lying on your left side with knees pulled up to the chest (it is not a barium enema).

Have you ever had a sigmoidoscopy?

- No
- Yes → Please state the **age** and **reason** for your first and most recent sigmoidoscopy.

	Age	Reason
First sigmoidoscopy	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input type="radio"/> For routine exam <input type="radio"/> For symptoms
Most recent sigmoidoscopy	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	<input type="radio"/> For routine exam <input type="radio"/> For symptoms

17. In the past two years, have you had...
(If yes, mark all that apply.)

	No	Yes, for routine exams	Yes, for symptoms
A physical exam?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PSA blood test for prostate cancer screening?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A prostate biopsy or rectal ultrasound for prostate examination?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

18. Current usual blood pressure
(if checked within 2 years):

Systolic (higher number):

- Unknown/not checked in 2 years
- <105 mmHg 145-164
- 105-124 165-184
- 125-144 185+

Diastolic (lower number):

- Unknown/not checked in 2 years
- <65 mmHg 95-114
- 65-84 115+
- 85-94

MEDICATIONS/VITAMINS

19. In the past two years , have you used any of the following medications on a regular basis?		No	Yes
CHOLESTEROL-LOWERING <i>for example:</i> Mevacor, Zocor, Pravachol, Lipitor, Lipid, Lescol, Questran, (lovastatin), etc.		<input type="radio"/>	<input type="radio"/>
FOR HEART OR BLOOD PRESSURE:			
Calcium Blocker	<i>for example:</i> Procardia, Cardizem, Norvasc, Calan, Adalat, Sular, (verapamil, amlodipine), etc.	<input type="radio"/>	<input type="radio"/>
Beta Blocker	<i>for example:</i> Lopressor, Tenormin, Inderal, Cogard, (atenolol, metoprolol), etc.	<input type="radio"/>	<input type="radio"/>
ACE Inhibitor	<i>for example:</i> Vasotec, Zestril, Capoten, Prinivil, Lotensin, Accupril, Monopril, (captopril), etc.	<input type="radio"/>	<input type="radio"/>
Diuretic	<i>for example:</i> Lasix, Lozol, (triamterene, HCTZ, furosemide, thiazides), etc.	<input type="radio"/>	<input type="radio"/>
Other	<i>(Mark here if unsure of heart or blood pressure medication category.)</i>	<input type="radio"/>	<input type="radio"/>
FOR URINARY SYMPTOMS OR OTHER REASONS:			
Finasteride	<i>for example:</i> Proscar	<input type="radio"/>	<input type="radio"/>
Alpha Blocker	<i>for example:</i> Hytrin, Cardura, (doxazosin, terazosin), etc.	<input type="radio"/>	<input type="radio"/>
Viagra		<input type="radio"/>	<input type="radio"/>
FOR STOMACH ACID:			
H2 Blocker	<i>for example:</i> Zantac, Pepcid, Tagamet, Axid, (cimetidine, ranitidine, famotidine, nizatidine), etc.	<input type="radio"/>	<input type="radio"/>
Proton (or gastric acid) pump inhibitors	<i>for example:</i> Prilosec, Prevacid, Protonix, AcipHex, (omeprazole, lansoprazole, pantoprazole, rabeprazole)	<input type="radio"/>	<input type="radio"/>
Other acid-suppression or anti-ulcer drugs	<i>for example:</i> Cytotec (misoprostol), Clindex, Clinoxide, Lidoxide, Zebrax, etc.	<input type="radio"/>	<input type="radio"/>
Other antacids	<i>for example:</i> Tums, Rolaids, Maalox, Mylanta, etc.	<input type="radio"/>	<input type="radio"/>
ANTIDEPRESSANT	<i>for example:</i> Prozac, Zoloft, Paxil, Effexor, Serzone, Elavil, (amitriptyline, nortriptyline), etc.	<input type="radio"/>	<input type="radio"/>
FOR DIABETES OR BLOOD SUGAR:			
Insulin Injections		<input type="radio"/>	<input type="radio"/>
Oral medications		<input type="radio"/>	<input type="radio"/>
BLOOD THINNERS	<i>for example:</i> Coumadin, (warfarin)	<input type="radio"/>	<input type="radio"/>
THYROID MEDICATIONS	<i>for example:</i> Synthroid, Levothroid, Levoxyl, L-thyroxine, Levo-T, (levothyroxine)	<input type="radio"/>	<input type="radio"/>

20. Have you ever been treated **with antibiotics** for *Helicobacter pylori* (*H. pylori*) infection or peptic ulcer (including ulcer of the duodenum or stomach)?

No

Yes → How old were you when first treated?

Age

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21. Multi-vitamins contain 10 or more vitamins and/or minerals. (For example: One-A-Day and Centrum Silver.)

Do you **currently** take a **multi-vitamin**?

(Please do **not** include additional individual supplements or eye health vitamins such as OcuVite.)

- No
- Yes →

How many multi-vitamin pills do you take <u>per week</u> ?			
<input type="radio"/> 2 or fewer	<input type="radio"/> 3-5	<input type="radio"/> 6-9	<input type="radio"/> 10 or more
Does your <u>multi-vitamin</u> include the following nutrients? (Please check label.)			
Selenium	Iron		
<input type="radio"/> No	<input type="radio"/> No		
<input type="radio"/> Yes	<input type="radio"/> Yes		

22. Do you take a special eye health vitamin combination (such as OcuVite or Icap)?

- No
- Yes →

How many eye health vitamin pills do you take <u>per week</u> ?			
<input type="radio"/> 2 or fewer	<input type="radio"/> 3-5	<input type="radio"/> 6-9	<input type="radio"/> 10 or more

23. **NOT counting multi-vitamins or eye health vitamins reported above**, do you regularly take any of the following supplements, individually, or in combinations? (If yes, please mark pills per week and amount in each pill. If you take a supplement with more than one vitamin, please repeat information on pills per week for each vitamin.)

		Pills Per Week	Amount In Each Pill
Vitamin A	<input type="radio"/> No <input type="radio"/> Yes →	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	→ <input type="radio"/> 7,500 IU or less <input type="radio"/> 8,000 IU or more <input type="radio"/> Don't know
Beta Carotene	<input type="radio"/> No <input type="radio"/> Yes →	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	→ <input type="radio"/> 12,000 IU or less <input type="radio"/> 13,000 IU or more <input type="radio"/> Don't know
Vitamin C	<input type="radio"/> No <input type="radio"/> Yes →	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	→ <input type="radio"/> 450 mg or less <input type="radio"/> 500 mg or more <input type="radio"/> Don't know
Vitamin E	<input type="radio"/> No <input type="radio"/> Yes →	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	→ <input type="radio"/> 250 IU or less <input type="radio"/> 300 IU or more <input type="radio"/> Don't know
Selenium	<input type="radio"/> No <input type="radio"/> Yes →	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	→ <input type="radio"/> 135 mcg or less <input type="radio"/> 140 mcg or more <input type="radio"/> Don't know
Folic Acid	<input type="radio"/> No <input type="radio"/> Yes →	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	→ <input type="radio"/> 300 mcg or less <input type="radio"/> 350 mcg or more <input type="radio"/> Don't know
Vitamin B6	<input type="radio"/> No <input type="radio"/> Yes →	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	→ <input type="radio"/> 35 mg or less <input type="radio"/> 40 mg or more <input type="radio"/> Don't know
Niacin	<input type="radio"/> No <input type="radio"/> Yes →	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	→ <input type="radio"/> 300 mg or less <input type="radio"/> 400 mg or more <input type="radio"/> Don't know
Calcium <small>(Include Calcium In Turns, etc.) (1 Turn = 200 mg. elemental calcium)</small>	<input type="radio"/> No <input type="radio"/> Yes →	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	→ <input type="radio"/> 350 mg or less <input type="radio"/> 400 mg or more <input type="radio"/> Don't know
Vitamin D	<input type="radio"/> No <input type="radio"/> Yes →	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	→ <input type="radio"/> 400 IU or less <input type="radio"/> 450 IU or more <input type="radio"/> Don't know
Zinc	<input type="radio"/> No <input type="radio"/> Yes →	<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>	→ <input type="radio"/> 45 mg or less <input type="radio"/> 50 mg or more <input type="radio"/> Don't know

24. 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"/>
Regular or extra strength aspirin (163 mg or more) <i>for example:</i> Bufferin, Anacin, Bayer, Excedrin, Ecotrin, etc.	<input type="radio"/>	<input type="text"/>	<input type="text"/>	→	<input type="text"/>	<input type="text"/>
Ibuprofen <i>for example:</i> Motrin, Advil, Nuprin, Mediprin, etc.	<input type="radio"/>	<input type="text"/>	<input type="text"/>	→	<input type="text"/>	<input type="text"/>
COX2 inhibitors <i>for example:</i> Celebrex (celecoxib), Vioxx (rofecoxib), etc.	<input type="radio"/>	<input type="text"/>	<input type="text"/>	→	<input type="text"/>	<input type="text"/>
Acetaminophen <i>for example:</i> Tylenol, Phenaphen, etc.	<input type="radio"/>	<input type="text"/>	<input type="text"/>	→	<input type="text"/>	<input type="text"/>
Other anti-inflammatory analgesics <i>for example:</i> Naprosyn, Anaprox, Aleve, Voltaren, Feldene, Toradol, Indocin, etc.	<input type="radio"/>	<input type="text"/>	<input type="text"/>	→	<input type="text"/>	<input type="text"/>

25. Have you ever taken any of the following herbals or other compounds at least once per week, either individually or as part of another supplement (e.g., multi-vitamin)? Include all forms (e.g., pills, powders and liquids). (Leave blank for **NO**.)

Saw Palmetto

- Yes, currently use →
- Only took in past

Days per week?	Years taken in lifetime?
<input type="radio"/> 1-3	<input type="radio"/> 0-2
<input type="radio"/> 4-6	<input type="radio"/> 3-5
<input type="radio"/> 7	<input type="radio"/> 6+

PC-Spes

- Yes, currently use →
- Only took in past

Days per week?	Years taken in lifetime?
<input type="radio"/> 1-3	<input type="radio"/> 0-2
<input type="radio"/> 4-6	<input type="radio"/> 3-5
<input type="radio"/> 7	<input type="radio"/> 6+

Glucosamine

- Yes, currently use →
- Only took in past

Days per week?	Years taken in lifetime?
<input type="radio"/> 1-3	<input type="radio"/> 0-2
<input type="radio"/> 4-6	<input type="radio"/> 3-5
<input type="radio"/> 7	<input type="radio"/> 6+

Coenzyme Q10

- Yes, currently use →
- Only took in past

Days per week?	Years taken in lifetime?
<input type="radio"/> 1-3	<input type="radio"/> 0-2
<input type="radio"/> 4-6	<input type="radio"/> 3-5
<input type="radio"/> 7	<input type="radio"/> 6+

Green Tea

- Yes, currently use →
- Only took in past

Days per week?	Years taken in lifetime?
<input type="radio"/> 1-3	<input type="radio"/> 0-2
<input type="radio"/> 4-6	<input type="radio"/> 3-5
<input type="radio"/> 7	<input type="radio"/> 6+

Garlic Supplement

- Yes, currently use →
- Only took in past

Days per week?	Years taken in lifetime?
<input type="radio"/> 1-3	<input type="radio"/> 0-2
<input type="radio"/> 4-6	<input type="radio"/> 3-5
<input type="radio"/> 7	<input type="radio"/> 6+

26. Do you currently use any of these products at least once per week, either individually or as part of another supplement (e.g., multi-vitamin)? Include all forms (e.g., pills, powders and liquids). (Mark all that apply.)

- Gingko Biloba
- Echinacea
- Lycopene
- Lutein
- Ginseng
- Flavonoids
- St. John's Wort
- Soy supplements or isoflavones
- Other

EXERCISE

27. What is your **normal** walking pace outdoors?

- Slow (less than 2 mph)
- Normal, average (2 to 2.9 mph)
- Brisk pace (3 to 3.9 mph)
- Very brisk, striding (4 mph or faster)
- Unable to walk

28. How many **flights** of stairs (not individual steps) do you climb **up** daily?

- No flights
- 1-2 flights
- 3-4 flights
- 5-9 flights
- 10-14 flights
- 15 or more flights

29. **During the past year**, what was your **average total time per week** spent at each of the following activities?

Average Total Time Per Week

	None	1-39 min.	40-89 min.	1.5 hrs.	2-3 hrs.	4-6 hrs.	7-10 hrs.	11-20 hrs.	21-30 hrs.	31-40 hrs.	40+ hrs.
Sitting at work.	<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"/>
Sitting or driving in a car, bus, or train.	<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"/>
Sitting or lying watching TV or VCR.	<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"/>
Sitting or lying reading.	<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"/>
Other sitting (for example, at desk or games).	<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"/>

30. The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much? (Mark one response on each line.)

	Yes, Limited A Lot	Yes, Limited A Little	No, Not Limited At All
Lifting or carrying groceries	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing several flights of stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Climbing one flight of stairs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking more than a mile	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking several blocks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Walking one block	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bathing or dressing yourself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

31. **During the past year**, what was your **average total time per week** spent at each of the following activities?

Average Total Time Per Week



	None	1-19 min.	20-59 min.	1 hr.	1-1.5 hrs.	2-3 hrs.	4-6 hrs.	7-10 hrs.	11+ hrs.
Walking (including walking at golf)	<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"/>
Jogging/Running	<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"/>
Lap Swimming	<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"/>
Tennis or Racquetball	<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"/>
Bicycling/Aerobic exercise machines	<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"/>
Aerobics/Calisthenics	<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"/>
Dancing	<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"/>
Gardening, Mowing, Planting, etc.	<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"/>
Low intensity exercise (e.g., Yoga, Stretching)	<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"/>
Weight training or resistance exercises (Include free weights or machines such as Nautilus)	<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"/>

SUN SENSITIVITY

Sunburn is a reddening of the skin that lasts at least 12 hours after you have been outdoors in the sun.

32. Suppose that after several months of not being in the sun, you went out in the sun without a hat, sunscreen, or protective clothing for an hour. Would you...*(check only one)*

- Sunburn with blisters
- Sunburn with peeling for a few days
- Sunburn without peeling
- Darken without sunburn
- Not have anything happen
- Don't know/not sure

33. How would you describe your natural skin color on parts of your body not exposed to the sun?

- Very fair
- Fair
- Medium
- Olive
- Light brown
- Dark brown
- Don't know

34. How often have you had a severe and painful sunburn at each of these areas on the body as a child/adolescent?

	Never	1-2 times	3-5 times	6+ times
Back and shoulders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lower limbs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Face or arms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
All over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

35. How often have you had a severe and painful sunburn at each of these areas on the body as an adult?

	Never	1-2 times	3-5 times	6+ times
Back and shoulders	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Lower limbs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Face or arms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
All over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

FAMILY HISTORY

36. 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:

	Mark here for yes	Relative's age at diagnosis
Prostate cancer:	<input type="radio"/> Father	<input type="text"/> <input type="text"/>
	<input type="radio"/> One brother	<input type="text"/> <input type="text"/>
	<input type="radio"/> Additional brother	<input type="text"/> <input type="text"/>
	<input type="radio"/> Additional brother	<input type="text"/> <input type="text"/>
	<input type="radio"/> Son	<input type="text"/> <input type="text"/>
<input type="radio"/> None of the Above		

	Mark here for yes	Relative's age at diagnosis
Breast cancer:	<input type="radio"/> Mother	<input type="text"/> <input type="text"/>
	<input type="radio"/> One sister	<input type="text"/> <input type="text"/>
	<input type="radio"/> Additional sister	<input type="text"/> <input type="text"/>
	<input type="radio"/> Additional sister	<input type="text"/> <input type="text"/>
	<input type="radio"/> Daughter	<input type="text"/> <input type="text"/>
<input type="radio"/> None of the Above		

Colon or Rectal cancer:	<input type="radio"/> Mother	<input type="text"/> <input type="text"/>
	<input type="radio"/> Father	<input type="text"/> <input type="text"/>
	<input type="radio"/> One sister	<input type="text"/> <input type="text"/>
	<input type="radio"/> Additional sister	<input type="text"/> <input type="text"/>
	<input type="radio"/> One brother	<input type="text"/> <input type="text"/>
	<input type="radio"/> Additional brother	<input type="text"/> <input type="text"/>
	<input type="radio"/> Daughter	<input type="text"/> <input type="text"/>
<input type="radio"/> Son	<input type="text"/> <input type="text"/>	
<input type="radio"/> None of the Above		

Ovarian cancer:	<input type="radio"/> Mother	<input type="text"/> <input type="text"/>
	<input type="radio"/> One sister	<input type="text"/> <input type="text"/>
	<input type="radio"/> Additional sister	<input type="text"/> <input type="text"/>
	<input type="radio"/> Daughter	<input type="text"/> <input type="text"/>
<input type="radio"/> None of the Above		

Pancreatic cancer:	<input type="radio"/> Mother	<input type="text"/> <input type="text"/>
	<input type="radio"/> Father	<input type="text"/> <input type="text"/>
	<input type="radio"/> Sister	<input type="text"/> <input type="text"/>
	<input type="radio"/> Brother	<input type="text"/> <input type="text"/>
	<input type="radio"/> None of the Above	

Thank you for your quick response.

Please return questionnaire in the postage-paid envelope provided to:
CANCER PREVENTION STUDY, PO Box 64761, ST PAUL, MN 55164-9333