American Cancer Society®

WOMEN

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 → [ ]

○ No, my birthday is: Month [ ][ ] Day [ ][ ] Year [ ][ ]

2. Is this your correct state of birth?

○ Yes, this is my birth state → [ ]

○ No, my birth state is: [ ][ ]

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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:

- 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.

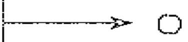
EXAMPLES:

Correct: I K 2 5 Incorrect: a 2 k

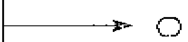
Please **PRINT** where applicable.

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

4. What is your **current** living arrangement?
   - ○ Alone
   - ○ With spouse or partner
   - ○ With other family
   - ○ Assisted living
   - ○ Nursing home
   - ○ Other

5. What is your **current** work status?
   - ○ Retired
   - ○ Work full-time
   - ○ Work part-time
   - ○ Volunteer
   - ○ Homemaker
   - ○ Disabled

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

   [ ][ ][ ] Pounds

7. Do you **currently** smoke cigarettes?
   - ○ No
   - ○ Yes → How many per day?
     - ○ 1-4 cigarettes
     - ○ 5-14
     - ○ 15-24
     - ○ 25-34
     - ○ 35-44
     - ○ 45 or more

8. In general, would you say your health is:
   - ○ Excellent
   - ○ Very Good
   - ○ Good
   - ○ Fair
   - ○ Poor

MEDICAL

9. Has a physician ever told you that you had any of the following conditions? (If not, mark ***never***; if yes, mark year ***first*** diagnosed.)

Fibrocystic or other benign breast disease
- ○ Never
- ○ Before October 1999
- ○ Oct. 1999 - Sept. 2001
- ○ After September 2001

Benign polyp of the colon or rectum
- ○ Never
- ○ Before October 1999
- ○ Oct. 1999 - Sept. 2001
- ○ After September 2001

Basal cell or squamous cell skin cancer
- ○ Never
- ○ Before October 1999
- ○ Oct. 1999 - Sept. 2001
- ○ After September 2001

10. Has a physician ever told you that you had any of the following **cancers**?

Breast cancer
- ○ Never
- ○ Before October 1999
- ○ Oct. 1999 - Sept. 2001
- ○ After September 2001

Cancer of the uterus or endometrium
- ○ Never
- ○ Before October 1999
- ○ Oct. 1999 - Sept. 2001
- ○ After September 2001

Lung or bronchial cancer
- ○ Never
- ○ Before October 1999
- ○ Oct. 1999 - Sept. 2001
- ○ After September 2001

Colon or rectal cancer
- ○ Never
- ○ Before October 1999
- ○ Oct. 1999 - Sept. 2001
- ○ After September 2001

Bladder cancer
- ○ Never
- ○ Before October 1999
- ○ Oct. 1999 - Sept. 2001
- ○ After September 2001

Lymphoma
- ○ Never
- ○ Before October 1999
- ○ Oct. 1999 - Sept. 2001
- ○ After September 2001

Other cancer (If you have been diagnosed with another type of cancer, please specify type of cancer below.)
- ○ Never
- ○ Before October 1999
- ○ Oct. 1999 - Sept. 2001
- ○ After September 2001

→ *Specify other cancer not mentioned in questions 9 or 10.*

[ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

11. 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**.)

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

WOMEN'S HEALTH ISSUES

12. Have you had your uterus removed?
    - ○ No
    - ○ Yes → Date of surgery:
      - ○ Before October 1, 1999
      - ○ After or on October 1, 1999

13. Have you had either of your ovaries surgically removed?
    - ○ No
    - ○ Yes → How many ovaries do you have **remaining**?
      - ○ None
      - ○ One
      - ○ Don't Know

14. Since September 1999, have you used female replacement hormones other than oral contraceptives?
    - ○ No
    - ○ Yes

a. How many months did you use them during the **24-month period** between SEPTEMBER 1999 and SEPTEMBER 2001?

○ 1-4 months ○ 5-9 months ○ 10-14 months
○ 15-19 months ○ 20-24 months ○ Used **only** after September 2001

b. Are you currently using them (within the last month)?

○ Yes, currently ○ No, not currently

c. Mark the types of hormones you have used the **longest** during this **24-month period**.

Combined:
○ Prempro (Pink) ○ Combipatch
○ Prempro (Blue) ○ FemHRT
○ Premphase

Estrogen:
○ Oral Premarin ○ Ogen ○ Estratest
○ Patch Estrogen ○ Estrace ○ Other Estrogen
○ Vaginal Estrogen

Progesterone/Progestin:
○ Provera/Cycrin/MPA ○ Micronized (e.g. Prometrium)
○ Vaginal ○ Other Progesterone

Other types of hormones used:
○ Testosterone ○ Other

d. What was your pattern of hormone use (please mark number of days used each month)?

Oral or Patch Estrogen (number of days used each month):
○ Not used ○ 28 or more days ○ 19-27 days
○ 9-18 days ○ 1-8 days ○ less than 1 day each month

Progesterone (number of days used each month):
○ Not used ○ 28 or more days ○ 19-27 days
○ 9-18 days ○ 1-8 days ○ less than 1 day each month

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	☐☐	○ For routine exam ○ For symptoms
Most recent colonoscopy	☐☐	○ For routine exam ○ 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	☐☐	○ For routine exam ○ For symptoms
Most recent sigmoidoscopy	☐☐	○ For routine exam ○ 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?	○	○	○
Mammogram?	○	○	○
Pap smear?	○	○	○

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

Systolic (higher number):

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

Diastolic (lower number):

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

MEDICATIONS/VITAMINS

19. In the **past two years**, have you used any of the following medications on a **regular** basis?			No	Yes
CHOLESTEROL-LOWERING	*for example:*	Mevacor, Zocor, Pravachol, Lipitor, 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, Cogard, (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, (cimetidine, ranitidine, famotidine, nizatidine), etc.	○	○
Proton (or gastric acid) pump inhibitors	*for example:*	Prilosec, Prevacid, Protonix, AcipHex, (omeprazole, lansoprazole, pantoprazole, rabeprazole)	○	○
Other acid-suppression or anti-ulcer drugs	*for example:*	Cytotec (misoprostol), Clindex, Clinoxide, Lidoxide, Zebrax, etc.	○	○
Other antacids	*for example:*	Tums, Rolaids, Maalox, Mylanta, etc.	○	○
ANTIDEPRESSANT	*for example:*	Prozac, Zoloft, Paxil, Effexor, Serzone, Elavil, (amitriptyline, nortriptyline), etc.	○	○
FOR DIABETES OR BLOOD SUGAR:				
Insulin Injections			○	○
Oral medications			○	○
BLOOD THINNERS	*for example:*	Coumadin, (warfarin)	○	○
THYROID MEDICATIONS	*for example:*	Synthroid, Levothroid, Levoxyl, L-thyroxine, Levo-T, (levothyroxine)	○	○
TAMOXIFEN	*for example:*	Nolvadex, etc.	○	○

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 [ ][ ]

21. Are you **currently** using any of these medications for osteoporosis or other reason?

○ Evista (raloxifene) ○ Fosamax (alendronate) ○ Miacalcin (calcitonin)

○ Didronel ○ Not using any of these

22. 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 per week?
○ 2 or fewer ○ 3-5 ○ 6-9 ○ 10 or more

Does your multi-vitamin include the following nutrients? (Please check label.)

Selenium
○ No
○ Yes

Iron
○ No
○ Yes

23. 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 per week?
○ 2 or fewer ○ 3-5 ○ 6-9 ○ 10 or more

24. **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	○ No	○ Yes →		→ ○ 7,500 IU or less	○ 8,000 IU or more	○ Don't know
Beta Carotene	○ No	○ Yes →		→ ○ 12,000 IU or less	○ 13,000 IU or more	○ Don't know
Vitamin C	○ No	○ Yes →		→ ○ 450 mg or less	○ 500 mg or more	○ Don't know
Vitamin E	○ No	○ Yes →		→ ○ 250 IU or less	○ 300 IU or more	○ Don't know
Selenium	○ No	○ Yes →		→ ○ 135 mcg or less	○ 140 mcg or more	○ Don't know
Folic Acid	○ No	○ Yes →		→ ○ 300 mcg or less	○ 350 mcg or more	○ Don't know
Vitamin B_6	○ No	○ Yes →		→ ○ 35 mg or less	○ 40 mg or more	○ Don't know
Niacin	○ No	○ Yes →		→ ○ 300 mg or less	○ 400 mg or more	○ Don't know
Calcium (Include Calcium in Tums, etc.) (1 Tums = 200 mg. elemental calcium)	○ No	○ Yes →		→ ○ 350 mg or less	○ 400 mg or more	○ Don't know
Vitamin D	○ No	○ Yes →		→ ○ 400 IU or less	○ 450 IU or more	○ Don't know
Zinc	○ No	○ Yes →		→ ○ 45 mg or less	○ 50 mg or more	○ Don't know

25. **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)		○	☐☐	→	☐☐
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.	○	☐☐	→	☐☐
COX2 inhibitors	*for example:* Celebrex (celecoxib), Vioxx (rofecoxib), etc.	○	☐☐	→	☐☐
Acetaminophen	*for example:* Tylenol, Phenaphen, etc.	○	☐☐	→	☐☐
Other anti-inflammatory analgesics	*for example:* Naprosyn, Anaprox, Aleve, Voltaren, Feldene, Toradol, Indocin, etc.	○	☐☐	→	☐☐

26. 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**.)

Glucosamine

○ Yes, currently use →
○ **Only** took in past

Days per week?	Years taken in lifetime?
○ 1-3	○ 0-2
○ 4-6	○ 3-5
○ 7	○ 6+

Coenzyme Q10

○ Yes, currently use →
○ **Only** took in past

Days per week?	Years taken in lifetime?
○ 1-3	○ 0-2
○ 4-6	○ 3-5
○ 7	○ 6+

Green Tea

○ Yes, currently use →
○ **Only** took in past

Days per week?	Years taken in lifetime?
○ 1-3	○ 0-2
○ 4-6	○ 3-5
○ 7	○ 6+

Garlic Supplement

○ Yes, currently use →
○ **Only** took in past

Days per week?	Years taken in lifetime?
○ 1-3	○ 0-2
○ 4-6	○ 3-5
○ 7	○ 6+

27. 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
○ Flavonoids
○ Ginseng
○ St. John's Wort
○ Soy supplements or isoflavones
○ Other

HEALTH CARE COVERAGE

28. 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 31)

29. 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

30. If you need treatment by a specialist, does your current plan **require** a referral or prior approval?
- ○ Yes
- ○ No
- ○ Don't know

EXERCISE

31. 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

32. 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

33. **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.	○	○	○	○	○	○	○	○	○	○	○
Sitting or driving in a car, bus, or train.	○	○	○	○	○	○	○	○	○	○	○
Sitting or lying watching TV or VCR.	○	○	○	○	○	○	○	○	○	○	○
Sitting or lying reading.	○	○	○	○	○	○	○	○	○	○	○
Other sitting (*for example*, at desk or games).	○	○	○	○	○	○	○	○	○	○	○

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

	None	Average Total Time Per Week: 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)	○	○	○	○	○	○	○	○	○
Jogging/Running	○	○	○	○	○	○	○	○	○
Lap Swimming	○	○	○	○	○	○	○	○	○
Tennis or Racquetball	○	○	○	○	○	○	○	○	○
Bicycling/Aerobic exercise machines	○	○	○	○	○	○	○	○	○
Aerobics/Calisthenics	○	○	○	○	○	○	○	○	○
Dancing	○	○	○	○	○	○	○	○	○
Gardening, Mowing, Planting, etc.	○	○	○	○	○	○	○	○	○
Low intensity exercise (e.g., Yoga, Stretching)	○	○	○	○	○	○	○	○	○
Weight training or resistance exercises (Include free weights or machines such as Nautilus)	○	○	○	○	○	○	○	○	○

35. 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	○	○	○
Climbing *several* flights of stairs	○	○	○
Climbing *one* flight of stairs	○	○	○
Walking *more than a mile*	○	○	○
Walking *several* blocks	○	○	○
Walking *one* block	○	○	○
Bathing or dressing yourself	○	○	○

SUN SENSITIVITY

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

36. 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

37. 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

38. 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	○	○	○	○
Lower limbs	○	○	○	○
Face or arms	○	○	○	○
All over	○	○	○	○

39. 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	○	○	○	○
Lower limbs	○	○	○	○
Face or arms	○	○	○	○
All over	○	○	○	○

FAMILY HISTORY

40. 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
Breast cancer:	Ⓨ Mother	
	Ⓨ One sister	
	Ⓨ Additional sister	
	Ⓨ Additional sister	
	Ⓨ Daughter	
	○ **None of the Above**	
Ovarian cancer:	Ⓨ Mother	
	Ⓨ One sister	
	Ⓨ Additional sister	
	Ⓨ Daughter	
	○ **None of the Above**	
Pancreatic cancer:	Ⓨ Mother	
	Ⓨ Father	
	Ⓨ Sister	
	Ⓨ Brother	
	○ **None of the Above**	

	Mark here for yes	Relative's age at diagnosis
Prostate cancer:	Ⓨ Father	
	Ⓨ One brother	
	Ⓨ Additional brother	
	Ⓨ Additional brother	
	Ⓨ Son	
	○ **None of the Above**	
Colon or Rectal cancer:	Ⓨ Mother	
	Ⓨ Father	
	Ⓨ One sister	
	Ⓨ Additional sister	
	Ⓨ One brother	
	Ⓨ Additional brother	
	Ⓨ Daughter	
	Ⓨ Son	
	○ **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