

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 19<sup>th</sup> anniversary of your participation in the Cancer Prevention Study. As always, thank you for your continuing support of this research. Your careful responses to the questionnaires contribute to many scientific publications on important topics.

The attached **very brief** questionnaire asks only for the most important information necessary for continuing 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:

- 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                      Incorrect

I  K  2  5       a  2  K  †

    

    

Please **PRINT** where applicable.

**START 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:

    →

**GENERAL**

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

Pounds

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

- No
- Yes

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

- Excellent
- Very Good
- Good
- Fair
- Poor

6. 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"/>
Colonoscopy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sigmoidoscopy?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**MEDICAL**

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

**Enlarged prostate, not surgically treated**

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

**Enlarged prostate, surgically treated**

- 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

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

**Prostate cancer**

- 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 7 or 8.

**MEDICATIONS/EXERCISE**

9. 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**?

- No
- Yes

How many multi-vitamin pills do you take per week?

2 or fewer       3-5       6-9       10 or more

10. **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

<b>Aspirin</b> 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"/>
<b>Ibuprofen</b> <i>for example:</i> Motrin, Advil, Nuprin, Mediprin, etc.	<input type="radio"/>	<input type="text"/>	<input type="text"/>	→	<input type="text"/>	<input type="text"/>
<b>COX2 inhibitors</b> <i>for example:</i> Celebrex (celecoxib), Vioxx (rofecoxib), etc.	<input type="radio"/>	<input type="text"/>	<input type="text"/>	→	<input type="text"/>	<input type="text"/>
<b>Acetaminophen</b> <i>for example:</i> Tylenol, Phenaphen, etc.	<input type="radio"/>	<input type="text"/>	<input type="text"/>	→	<input type="text"/>	<input type="text"/>
<b>Other anti-inflammatory analgesics</b> <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"/>

11. **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	<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"/>

**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 55164-9332**