American Cancer Society®

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 being an active participant in the Cancer Prevention Study for over twenty years!

This short questionnaire will focus on your medical history and use of medications, vitamins, and supplements. These new questions will allow us to broaden and update the information you have already given us in the past.

Please continue to be a participant in this important study by completing and returning the attached questionnaire within 10 days. In addition, please verify that the information printed above is your full legal name and correct address and 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. 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

Do you have an e-mail address?
If you do, please print your e-mail address in the box below:

We will not release your e-mail address to anyone!

1. Is this your correct date of birth?
   - ○ Yes
   - ○ No, my birthday is: Month Day Year

2. Is this your correct state of birth?
   - ○ Yes
   - ○ 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 or dark pencil.
- Do not use 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, erase cleanly (pencil) or place an "X" through the first mark (pen), and mark the oval for your preferred answer.

EXAMPLES:

Correct Incorrect

I K 2 5 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. In general, would you say your health is:

○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

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

● ☐☐☐ Pounds

5. 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

MEDICAL

6. 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 2001
○ Oct. 2001 - July 2003
○ After July 2003

Enlarged prostate, surgically treated

○ Never
○ Before October 2001
○ Oct. 2001 - July 2003
○ After July 2003

Benign polyp of the colon or rectum

○ Never
○ Before October 2001
○ Oct. 2001 - July 2003
○ After July 2003

Basal cell or squamous cell skin cancer

○ Never
○ Before October 2001
○ Oct. 2001 - July 2003
○ After July 2003

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

Prostate cancer

○ Never
○ Before October 2001
○ Oct. 2001 - July 2003
○ After July 2003

Lung or bronchial cancer

○ Never
○ Before October 2001
○ Oct. 2001 - July 2003
○ After July 2003

Colon or rectal cancer

○ Never
○ Before October 2001
○ Oct. 2001 - July 2003
○ After July 2003

Bladder cancer

○ Never
○ Before October 2001
○ Oct. 2001 - July 2003
○ After July 2003

Lymphoma

○ Never
○ Before October 2001
○ Oct. 2001 - July 2003
○ After July 2003

Other cancer (If you have been diagnosed with another type of cancer, please specify type of cancer below.)

○ Never
○ Before October 2001
○ Oct. 2001 - July 2003
○ After July 2003

→ *Specify other cancer not mentioned in questions 6 or 7.* ●

☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

8. 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 2001	October 2001 - July 2003	After July 2003
Diabetes mellitus	○	○	○	○
Elevated cholesterol	○	○	○	○
High blood pressure	○	○	○	○
Myocardial infarction (heart attack) or angina pectoris	○	○	○	○
Hospitalized for MI?	○	○	○	○
Coronary bypass or angioplasty	○	○	○	○
Stroke (CVA) or 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	○	○	○	○

9. **During the past month**, how often have you:

	Not at all	Some-times	Less than half the time	About half the time	Most of the time	Almost always
Had a sensation of not emptying your bladder completely after you finished urinating?	○	○	○	○	○	○
Had to urinate again in less than two hours after you finished urinating?	○	○	○	○	○	○
Found you stopped and started again several times when you urinated?	○	○	○	○	○	○
Found it difficult to postpone urination?	○	○	○	○	○	○
Had a weak urinary stream?	○	○	○	○	○	○
Had to push or strain to begin urinating?	○	○	○	○	○	○

10. **On a typical night, during the past month,** how many times did you get up to urinate from the time you went to bed until the time you got up in the morning?

○ None ○ 1 time ○ 2 times ○ 3 times ○ 4 times ○ 5+ times

SCREENING

11. In the **past two years**, have you had any of the following? (If yes, **mark all that apply**.)

	No	Yes, for routine exams	Yes, for symptoms
A physical exam	○	○	○
PSA blood test for prostate cancer screening	○	○	○
A prostate biopsy or rectal ultrasound for prostate examination	○	○	○
Colonoscopy	○	○	○
Sigmoidoscopy	○	○	○

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.

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).

MEDICATIONS/VITAMINS

12. 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, Corgard, (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 URINARY SYMPTOMS OR OTHER REASONS:				
Finasteride	*for example:*	Proscar, Propecia	○	○
Alpha Blocker	*for example:*	Hytrin, Cardura, Flomax, Minipress, (terazosin, doxazosin, tamsulosin, prazosin), etc.	○	○
Viagra			○	○
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, Nexium, (omeprazole, lansoprazole, pantoprazole, rabeprazole, esomeprazole)	○	○
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, Levo-T, (levothyroxine, L-thyroxine), etc.	○	○

13. 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 →

a. How many multi-vitamin pills do you take per week?
○ 2 or fewer ○ 3-5 ○ 6-9 ○ 10 or more

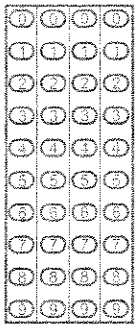
b. Does your multi-vitamin include the following nutrients? (Please check label.)

Selenium ○ No ○ Yes

Iron ○ No ○ Yes

c. What specific brand do you usually use?

Specify **brand & type** (e.g., Centrum Silver)



14. **NOT counting multi-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 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 (In Calcium supplement or separately)	○ No ○ Yes →		→ ○ 350 IU or less	○ 400 IU or more	○ Don't know
Zinc	○ No ○ Yes →		→ ○ 45 mg or less	○ 50 mg or more	○ Don't know

15. Are there other supplements that you take on a regular basis (singly or in combination)? **Mark all that apply.**

○ Glucosamine ○ Lutein ○ Garlic supplement ○ Lycopene ○ Saw Palmetto

16. **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.	○	→	
COX2 inhibitors	*for example:* Celebrex (celecoxib), Vioxx (rofecoxib), Bextra (valdecoxib), etc.	○	→	
Acetaminophen	*for example:* Tylenol, Phenaphen, etc.	○	→	
Other anti-inflammatory analgesics	*for example:* Naprosyn (naproxen), Anaprox, Aleve, Voltaren, Feldene, Clinoril, Indocin, etc.	○	→	

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

Questar / Eagan, MN / 30287C-CPS-II-MEN