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,

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

This **very brief** 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

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.

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!

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: I K 2 5

Incorrect: a 2 K +

Please **PRINT** where applicable.

START HERE

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:

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

6. 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	○	○	○
Mammogram	○	○	○
Pap smear	○	○	○
Colonoscopy	○	○	○
Sigmoidoscopy	○	○	○

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.)*

Fibrocystic or other benign breast disease	Benign polyp of the colon or rectum	Basal cell or squamous cell skin cancer
○ Never	○ Never	○ Never
○ Before October 2001	○ Before October 2001	○ Before October 2001
○ Oct. 2001 - July 2003	○ Oct. 2001 - July 2003	○ Oct. 2001 - July 2003
○ After July 2003	○ After July 2003	○ After July 2003

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

Breast cancer	Cancer of the uterus or endometrium	Lung or bronchial cancer
○ Never	○ Never	○ Never
○ Before October 2001	○ Before October 2001	○ Before October 2001
○ Oct. 2001 - July 2003	○ Oct. 2001 - July 2003	○ Oct. 2001 - July 2003
○ After July 2003	○ After July 2003	○ After July 2003

Colon or rectal cancer	Bladder cancer	Lymphoma
○ Never	○ Never	○ Never
○ Before October 2001	○ Before October 2001	○ Before October 2001
○ Oct. 2001 - July 2003	○ Oct. 2001 - July 2003	○ Oct. 2001 - July 2003
○ After July 2003	○ After 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 7 or 8.*

9. **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.	○		→	

WOMEN'S HEALTH ISSUES/VITAMINS

10. Since October 2001, have you used prescription female replacement hormones?

○ No
○ Yes → a. How many months did you use them since OCTOBER 2001?

○ 1-4 months ○ 10-14 months ○ 20-24 months
○ 5-9 months ○ 15-19 months ○ 25+ months

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

○ Yes, currently ○ No, not currently

c. Mark the type(s) of hormones you are CURRENTLY using.

Combined:

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

Estrogen:

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

Progesterone/Progestin:

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

11. 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

12. **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 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
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
Zinc	○ No ○ Yes →		→ ○ 45 mg or less	○ 50 mg or more	○ Don't know

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