Dear Cancer Prevention Study Participant,

As you may recall, you previously volunteered to be in the American Cancer Society's Cancer Prevention research Study. The goal of the research study is to look at how environmental and lifestyle factors play a role in cancer. You, along with 1.2 million American men and women have been enrolled in the study since 1982. If you choose to continue being a volunteer, we will send you a new questionnaire every few years in order to obtain your up-to-date health information. Your continued participation is critical to the success of this research study, which has as its objective the prevention of cancer.

As a research subject there is no direct benefit to you except the knowledge that you have made an important contribution to cancer research, the results of which may help prevent many people from getting cancer. We publish our results in medical journals and will update you with our findings in our yearly newsletters. The primary risk to you as a participant is the possibility of a breach in confidentiality. This is one of our top concerns and we strive to protect you by allowing only authorized personnel access to your private information, training all personnel to protect your privacy, and securely maintaining and storing data in locked and restricted areas. The only other risk that may arise is that thinking about some of your health issues may be upsetting. We have developed the questionnaire to be as sensitive as possible to this concern, and you can skip any question you are not comfortable answering.

Your participation is completely voluntary. You have the right to refuse to be in this study and stop participating at any time. Deciding not to continue participating or withdrawing at a later date will not affect in any way your current or future medical care or other benefits to which you are otherwise entitled, as your information will never be shared with anyone outside our research team. If you decide to continue participating, we ask that you complete and return this questionnaire, which will take approximately 30 minutes to complete.

If you have any questions about this study call Peter Briggs, Co-Director of Study Management. Call Dr. James W. Keller, Chair of the Emory University Institutional Review Board, if you have any questions about your rights as a participant in this research study. Their telephone numbers are: James W Keller, M.D. (404) 727-5646 Peter Briggs: (800) 646-7853 or (404) 329-7987.

Thank you again for your participation.

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 your participation in the Cancer Prevention Study! We are proud and grateful that you continue to volunteer in this remarkable study of cancer causes and prevention.

To continue our contribution to cancer research, we must periodically update information regarding your lifestyle, screening practices, use of medications/vitamins, and family history. The new questionnaire addresses all of these topics. We hope you will take the time to carefully complete the survey and return it to us 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 invaluable contribution to this study. 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 OR GEL PENS.**
- 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. 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
- ○ 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

9. Do you usually use a cane or walker?

- ○ No
- ○ Yes

10. Do you have difficulty with your balance?

- ○ No
- ○ Yes

11. Number of times you have fallen to the ground in the past year:

- ○ None
- ○ 1
- ○ 2
- ○ 3
- ○ 4
- ○ 5-9
- ○ 10 or more

SCREENING

12. 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	○	○	○
Colonoscopy	○	○	○
Sigmoidoscopy	○	○	○
A prostate biopsy or rectal ultrasound for prostate examination	○	○	○
PSA blood test for prostate cancer screening	○	○	○

If "yes" for PSA screening, was your PSA elevated?
○ No ○ Unknown ○ Yes

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).

MEDICAL

13. 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 August 2003
- ○ Aug. 2003 - July 2005
- ○ After July 2005

Enlarged prostate, surgically treated

- ○ Never
- ○ Before August 2003
- ○ Aug. 2003 - July 2005
- ○ After July 2005

Benign polyp of the colon or rectum

- ○ Never
- ○ Before August 2003
- ○ Aug. 2003 - July 2005
- ○ After July 2005

Basal cell or squamous cell skin cancer

- ○ Never
- ○ Before August 2003
- ○ Aug. 2003 - July 2005
- ○ After July 2005

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

Prostate cancer

- ○ Never
- ○ Before August 2003
- ○ Aug. 2003 - July 2005
- ○ After July 2005

Lung or bronchial cancer

- ○ Never
- ○ Before August 2003
- ○ Aug. 2003 - July 2005
- ○ After July 2005

Colon or rectal cancer

- ○ Never
- ○ Before August 2003
- ○ Aug. 2003 - July 2005
- ○ After July 2005

Bladder cancer

- ○ Never
- ○ Before August 2003
- ○ Aug. 2003 - July 2005
- ○ After July 2005

Lymphoma

- ○ Never
- ○ Before August 2003
- ○ Aug. 2003 - July 2005
- ○ After July 2005

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

- ○ Never
- ○ Before August 2003
- ○ Aug. 2003 - July 2005
- ○ After July 2005

→ ***Specify other cancer not mentioned in questions 13 or 14.***

15. Has a physician ever told you that you had any of the following conditions? (**If no, leave blank.** If yes, mark **yes** and **year of diagnosis** for each illness you have had diagnosed.)

	Mark here for YES	Year first diagnosed: Before August 2003	August 2003 - July 2005	After July 2005
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	○	○	○	○
Amyotrophic Lateral Sclerosis (ALS)	○	○	○	○
Emphysema or chronic bronchitis	○	○	○	○
Osteoporosis	○	○	○	○
Vertebral fracture, x-ray confirmed	○	○	○	○
Hip replacement	○	○	○	○
Hip fracture	○	○	○	○
Wrist or Colles' fracture	○	○	○	○
Osteoarthritis	○	○	○	○
Rheumatoid arthritis	○	○	○	○

EXERCISE

16. What is your **normal** walking pace?

- ○ 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

17. 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

18. **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
Standing or walking around at work or away from home	○	○	○	○	○	○	○	○	○	○	○
Standing or walking around at home	○	○	○	○	○	○	○	○	○	○	○
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)	○	○	○	○	○	○	○	○	○	○	○

19. 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
Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	○	○	○
Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	○	○	○
Lifting or carrying groceries	○	○	○
Climbing *several* flights of stairs	○	○	○
Climbing *one* flight of stairs	○	○	○
Bending, kneeling, or stooping	○	○	○
Walking *more than a mile*	○	○	○
Walking *several* blocks	○	○	○
Walking *one* block	○	○	○
Bathing or dressing yourself	○	○	○

20. **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 on treadmill and at golf)	○	○	○	○	○	○	○	○	○
Jogging (slower than 10 minutes/mile)	○	○	○	○	○	○	○	○	○
Running (10 minutes/mile or faster)	○	○	○	○	○	○	○	○	○
Lap Swimming	○	○	○	○	○	○	○	○	○
Tennis or Racquetball	○	○	○	○	○	○	○	○	○
Bicycling/Stationary bike	○	○	○	○	○	○	○	○	○
Other 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)	○	○	○	○	○	○	○	○	○

MEDICATIONS

21. Do you **currently** take any of the following cholesterol-lowering drugs?

○ Lipitor (atorvastatin) ○ Pravachol (pravastatin) ○ Lescol or Lescol XL (fluvastatin)
○ Zocor (simvastatin) ○ Crestor (rosuvastatin) ○ Mevacor or Altoprev (lovastatin)

If you marked any of the drugs above, what total dose per day do you take?

○ 5 mg ○ 10 mg ○ 20 mg ○ 40 mg ○ 60 mg ○ 80 mg

○ Caduet
○ Vytorin
○ Any other cholesterol-lowering drug not listed above, for example Lopid (gemfibrozil), Zetia (eztimibe), or Questran (cholestyramine)

22. In the **past two years**, have you used any of the following medications on a **regular** basis?

		No	Yes
FOR HEART OR BLOOD PRESSURE:			
Calcium Blocker	*for example:* Cartia, Lotrel, Plendil, Norvasc, (verapamil, amlodipine, diltiazem, nifedipine), etc.	○	○
Beta Blocker	*for example:* Toprol, Coreg, Inderal, Corgard, (atenolol, metoprolol), etc.	○	○
ACE Inhibitor	*for example:* Lotensin, Altace, Accupril, Monopril, (captopril, enalapril, lisinopril), etc.	○	○
Sartans	*for example:* Diovan, Cozaar, Avapro, Atacand, Tevetan, Mycardis, (valsartan, losartan, irbesartan, candesartan)	○	○
Diuretic	*for example:* Lasix, Lozol, (triamterene, HCTZ, furosemide, thiazides, spironolactone), etc.	○	○
Other	*(Mark here if unsure of heart or blood pressure medication category.)*	○	○
FOR URINARY SYMPTOMS OR OTHER REASONS:			
Viagra, Levitra, Cialis		○	○
Finasteride	*for example:* Proscar, Propecia	○	○
Alpha Blocker	*for example:* Hytrin, Cardura, Flomax, Minipress, (terazosin, doxazosin, tamsulosin, prazosin), etc	○	○
Other	*for example:* Detrol, Ditropan, Enablex	○	○
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.	○	○
ANTIDEPRESSANTS:			
SSRI	*for example:* Celexa, Paxil, Prozac, Zoloft, Lexapro	○	○
Tricyclic	*for example:* Elavil, (amitriptyline)	○	○
Other	*for example:* Effexor, Remeron, Wellbutrin, Desyrel (trazadone)	○	○
ANTIANXIETY	*for example:* Xanex, Ativan, Klonopin, Valium, Librium, Restoril, (alprozolam, lorazapam, clonazapam, diazepam, temazapam)	○	○
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.	○	○

23. **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.	○	□□ →	□□
Naprosyn (naproxen)		○	□□ →	□□
Other anti-inflammatory analgesics	*for example:* Anaprox, Aleve, Voltaren, Feldene, Clinoril, Indocin, etc.	○	□□ →	□□

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

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

25. On **average**, **during the past year**, how often did you drink regular or decaffeinated green tea?

○ Never
○ Less than once per month
○ 1-3 cups per month
○ 1 cup per week
○ 2-4 cups per week
○ 5-6 cups per week
○ 1 cup per day
○ 2-3 cups per day
○ 4-5 cups per day
○ 6+ cups per day

VITAMINS

26. 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		Iron		Lycopene	
○ No	○ Yes	○ No	○ Yes	○ No	○ Yes

27. **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
Vitamin B_{12}	○ No ○ Yes →		→ ○ 200 mcg or less	○ 250 mcg 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

FAMILY HISTORY

28. 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:	○ 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**	
Breast cancer:	○ Mother	
	○ One sister	
	○ Additional sister	
	○ Additional sister	
	○ Daughter	
	○ Additional 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**	

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