

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.



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 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

Month Day Year

No, my birthday is:

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 | † |
| → | ● | | |
| } → | X ● | | |

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

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 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Mammogram | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Pap smear | <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"/> |

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).

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 (except during pregnancy) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Elevated cholesterol | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| High blood pressure | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Myocardial infarction (heart attack) or angina pectoris | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Hospitalized for MI? → | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Coronary bypass or angioplasty | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Stroke (CVA) or TIA (Transient ischemic attack) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Carotid surgery (Endarterectomy) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Parkinson's Disease | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Amyotrophic Lateral Sclerosis (ALS) | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Emphysema or chronic bronchitis | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Osteoporosis | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Vertebral fracture, x-ray confirmed | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Hip replacement | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Hip fracture | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Wrist or Colles' fracture | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Osteoarthritis | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Rheumatoid arthritis | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |



WOMEN'S HEALTH ISSUES

16. Since AUGUST 2003, have you used prescription female replacement hormones?

No (If No, go to Question 17)

Yes

a. How many months did you use them since AUGUST 2003?

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 (If No, go to Question 17)

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

Combined estrogen and progestin in one pill or patch:

Prempro (pill):

peach

Other combination pill

blue

(e.g., Activella, Fem HRT, Ortho-Prefest, Premphase)

gold

ivory

Patch (e.g., CombiPatch, Climara-Pro)

Estrogen:

Premarin (pill):

green

Vaginal estrogen:

Cream or tablet

Other estrogen pill

blue

Ring (Estring)

(e.g., Cenestin, Estinyl,
Estrace, Menest, Ogen)

maroon

Ring (Femring)

white

Patch estrogen

yellow

(e.g., Alora, Climara, Esclim,
Estraderm, Vivelle, Vivelle-Dot)

Progesterone/Progestin:

Provera/Cycrin/MPA

Vaginal

Micronized (e.g., Prometrium)

Other Progesterone

Other types of hormones used:

Testosterone

Other

d. What is 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

1-8 days

19-27 days

less than 1 day each month

9-18 days

28 or more days

Progesterone (number of days used each month):

Not used

1-8 days

19-27 days

less than 1 day each month

9-18 days

28 or more days

EXERCISE

17. 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

18. 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

19. **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 | <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"/> | <input type="radio"/> | <input type="radio"/> |
| Standing or walking around at home | <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"/> | <input type="radio"/> | <input type="radio"/> |
| Sitting at work | <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"/> | <input type="radio"/> | <input type="radio"/> |
| Sitting or driving in a car, bus, or train | <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"/> | <input type="radio"/> | <input type="radio"/> |
| Sitting or lying watching TV or VCR | <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"/> | <input type="radio"/> | <input type="radio"/> |
| Sitting or lying reading | <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"/> | <input type="radio"/> | <input type="radio"/> |
| Other sitting (for example, at desk or games) | <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"/> | <input type="radio"/> | <input type="radio"/> |

20. 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 |
|---|-----------------------|-----------------------|------------------------|
| <i>Vigorous activities</i> , such as running, lifting heavy objects, participating in strenuous sports | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| <i>Moderate activities</i> , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Lifting or carrying groceries | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Climbing <i>several</i> flights of stairs | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Climbing <i>one</i> flight of stairs | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Bending, kneeling, or stooping | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Walking <i>more than a mile</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Walking <i>several blocks</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Walking <i>one block</i> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| Bathing or dressing yourself | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

21. **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) | <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 (slower than 10 minutes/mile) | <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"/> |
| Running (10 minutes/mile or faster) | <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/Stationary bike | <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"/> |
| Other 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 (include free weights or machines such as Nautilus) | <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"/> |

MEDICATIONS

22. 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 (ezetimibe), or Questran (cholestyramine)

23. 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 | <i>for example:</i> Cartia, Lotrel, Plendil, Norvasc, (verapamil, amlodipine, diltiazem, nifedipine), etc. | <input type="radio"/> | <input type="radio"/> |
| Beta Blocker | <i>for example:</i> Toprol, Coreg, Inderal, Corgard, (atenolol, metoprolol), etc. | <input type="radio"/> | <input type="radio"/> |
| ACE Inhibitor | <i>for example:</i> Lotensin, Altace, Accupril, Monopril, (captopril, enalapril, lisinopril), etc. | <input type="radio"/> | <input type="radio"/> |
| Sartans | <i>for example:</i> Diovan, Cozaar, Avapro, Atacand, Tevetan, Mycardis, (valsartan, losartan, irbesartan, candesartan) | <input type="radio"/> | <input type="radio"/> |
| Diuretic | <i>for example:</i> Lasix, Lozol, (triamterene, HCTZ, furosemide, thiazides, spironolactone), etc. | <input type="radio"/> | <input type="radio"/> |
| Other | <i>(Mark here if unsure of heart or blood pressure medication category.)</i> | <input type="radio"/> | <input type="radio"/> |
| FOR STOMACH ACID: | | | |
| H2 Blocker | <i>for example:</i> Zantac, Pepcid, Tagamet, Axid, (cimetidine, ranitidine, famotidine, nizatidine), etc. | <input type="radio"/> | <input type="radio"/> |
| Proton (or gastric acid) pump inhibitors | <i>for example:</i> Prilosec, Prevacid, Protonix, AcipHex, Nexium, (omeprazole, lansoprazole, pantoprazole, rabeprazole, esomeprazole) | <input type="radio"/> | <input type="radio"/> |
| Other acid-suppression or anti-ulcer drugs | <i>for example:</i> Cytotec (misoprostol), Clindex, Clinoxide, Lidoxide, Zebrax, etc. | <input type="radio"/> | <input type="radio"/> |
| Other antacids | <i>for example:</i> Tums, Roloids, Maalox, Mylanta, etc. | <input type="radio"/> | <input type="radio"/> |
| ANTIDEPRESSANTS: | | | |
| SSRI | <i>for example:</i> Celexa, Paxil, Prozac, Zoloft, Lexapro | <input type="radio"/> | <input type="radio"/> |
| Tricyclic | <i>for example:</i> Elavil, (amitriptyline) | <input type="radio"/> | <input type="radio"/> |
| Other | <i>for example:</i> Effexor, Remeron, Wellbutrin, Desyrel (trazadone) | <input type="radio"/> | <input type="radio"/> |
| ANTI-ANXIETY | <i>for example:</i> Xanax, Ativan, Klonopin, Valium, Librium, Restoril, (alprazolam, lorazepam, clonazepam, diazepam, temazepam) | <input type="radio"/> | <input type="radio"/> |
| FOR DIABETES OR BLOOD SUGAR: | | | |
| Insulin injections | | <input type="radio"/> | <input type="radio"/> |
| Oral medications | | <input type="radio"/> | <input type="radio"/> |
| BLOOD THINNERS | <i>for example:</i> Coumadin, (warfarin) | <input type="radio"/> | <input type="radio"/> |
| THYROID MEDICATIONS | <i>for example:</i> Synthroid, Levothyroid, Levoxyl, Levo-T, (levothyroxine, L-thyroxine), etc. | <input type="radio"/> | <input type="radio"/> |
| TAMOXIFEN | <i>for example:</i> Nolvadex | <input type="radio"/> | <input type="radio"/> |
| RALOXIFENE | <i>for example:</i> Evista | <input type="radio"/> | <input type="radio"/> |

24. In the **past two years**, have you used any of these medications on a **regular** basis for osteoporosis or other reason?

- Fosamax (alendronate)
- Actonel (risedronate)
- Calcimar, Cibacalcin, Miacalcin (calcitonin)
- Didronel
- Forteo injections (teriparatide)
- No

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) | <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: Bufferin, Anacin, Bayer, Excedrin, Ecotrin, etc.</i> | <input type="radio"/> | <input type="text"/> <input type="text"/> → | <input type="text"/> <input type="text"/> |
| Ibuprofen <i>for example: Motrin, Advil, Nuprin, Mediprin, etc.</i> | <input type="radio"/> | <input type="text"/> <input type="text"/> → | <input type="text"/> <input type="text"/> |
| COX2 inhibitors <i>for example: Celebrex (celecoxib), Vioxx (rofecoxib), Bextra (valdecoxib), etc.</i> | <input type="radio"/> | <input type="text"/> <input type="text"/> → | <input type="text"/> <input type="text"/> |
| Acetaminophen <i>for example: Tylenol, Phenaphen, etc.</i> | <input type="radio"/> | <input type="text"/> <input type="text"/> → | <input type="text"/> <input type="text"/> |
| Naprosyn (naproxen) | <input type="radio"/> | <input type="text"/> <input type="text"/> → | <input type="text"/> <input type="text"/> |
| Other anti-inflammatory analgesics <i>for example: Anaprox, Aleve, Voltaren, Feldene, Clinoril, Indocin, etc.</i> | <input type="radio"/> | <input type="text"/> <input type="text"/> → | <input type="text"/> <input type="text"/> |

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

- Glucosamine
- Lutein
- Garlic supplement
- Lycopene
- Soy supplements or isoflavones

27. 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

28. 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 <u>per week</u> ? | | | |
| <input type="radio"/> 2 or fewer | <input type="radio"/> 3-5 | <input type="radio"/> 6-9 | <input type="radio"/> 10 or more |
| b. Does your <u>multi-vitamin</u> include the following nutrients? (Please check label.) | | | |
| Selenium | Iron | Lycopene | |
| <input type="radio"/> No <input type="radio"/> Yes | <input type="radio"/> No <input type="radio"/> Yes | <input type="radio"/> No <input type="radio"/> Yes | <input type="radio"/> No <input type="radio"/> Yes |

29. **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 | <input type="radio"/> No <input type="radio"/> Yes → | | | → <input type="radio"/> 7,500 IU or less | <input type="radio"/> 8,000 IU or more | <input type="radio"/> Don't know |
| Beta Carotene | <input type="radio"/> No <input type="radio"/> Yes → | | | → <input type="radio"/> 12,000 IU or less | <input type="radio"/> 13,000 IU or more | <input type="radio"/> Don't know |
| Vitamin C | <input type="radio"/> No <input type="radio"/> Yes → | | | → <input type="radio"/> 450 mg or less | <input type="radio"/> 500 mg or more | <input type="radio"/> Don't know |
| Vitamin E | <input type="radio"/> No <input type="radio"/> Yes → | | | → <input type="radio"/> 250 IU or less | <input type="radio"/> 300 IU or more | <input type="radio"/> Don't know |
| Selenium | <input type="radio"/> No <input type="radio"/> Yes → | | | → <input type="radio"/> 135 mcg or less | <input type="radio"/> 140 mcg or more | <input type="radio"/> Don't know |
| Folic Acid | <input type="radio"/> No <input type="radio"/> Yes → | | | → <input type="radio"/> 300 mcg or less | <input type="radio"/> 350 mcg or more | <input type="radio"/> Don't know |
| Vitamin B₆ | <input type="radio"/> No <input type="radio"/> Yes → | | | → <input type="radio"/> 35 mg or less | <input type="radio"/> 40 mg or more | <input type="radio"/> Don't know |
| Vitamin B₁₂ | <input type="radio"/> No <input type="radio"/> Yes → | | | → <input type="radio"/> 200 mcg or less | <input type="radio"/> 250 mcg or more | <input type="radio"/> Don't know |
| Niacin | <input type="radio"/> No <input type="radio"/> Yes → | | | → <input type="radio"/> 300 mg or less | <input type="radio"/> 400 mg or more | <input type="radio"/> Don't know |
| Calcium (Include Calcium in Tums, etc.) (1 Tums = 200 mg elemental calcium) | <input type="radio"/> No <input type="radio"/> Yes → | | | → <input type="radio"/> 350 mg or less | <input type="radio"/> 400 mg or more | <input type="radio"/> Don't know |
| Vitamin D (In Calcium supplement or separately) | <input type="radio"/> No <input type="radio"/> Yes → | | | → <input type="radio"/> 350 IU or less | <input type="radio"/> 400 IU or more | <input type="radio"/> Don't know |
| Zinc | <input type="radio"/> No <input type="radio"/> Yes → | | | → <input type="radio"/> 45 mg or less | <input type="radio"/> 50 mg or more | <input type="radio"/> Don't know |

FAMILY HISTORY

30. 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: | <input type="radio"/> Mother | <input type="text"/> <input type="text"/> |
| | <input type="radio"/> One sister | <input type="text"/> <input type="text"/> |
| | <input type="radio"/> Additional sister | <input type="text"/> <input type="text"/> |
| | <input type="radio"/> Additional sister | <input type="text"/> <input type="text"/> |
| | <input type="radio"/> Daughter | <input type="text"/> <input type="text"/> |
| | <input type="radio"/> Additional daughter | <input type="text"/> <input type="text"/> |
| | <input type="radio"/> None of the Above | <input type="text"/> <input type="text"/> |

| | | |
|------------------------|---|---|
| Ovarian cancer: | <input type="radio"/> Mother | <input type="text"/> <input type="text"/> |
| | <input type="radio"/> One sister | <input type="text"/> <input type="text"/> |
| | <input type="radio"/> Additional sister | <input type="text"/> <input type="text"/> |
| | <input type="radio"/> Daughter | <input type="text"/> <input type="text"/> |
| | <input type="radio"/> None of the Above | <input type="text"/> <input type="text"/> |

| | | |
|---------------------------|---|---|
| Pancreatic cancer: | <input type="radio"/> Mother | <input type="text"/> <input type="text"/> |
| | <input type="radio"/> Father | <input type="text"/> <input type="text"/> |
| | <input type="radio"/> Sister | <input type="text"/> <input type="text"/> |
| | <input type="radio"/> Brother | <input type="text"/> <input type="text"/> |
| | <input type="radio"/> None of the Above | <input type="text"/> <input type="text"/> |

| | Mark here for YES ↓ | Relative's age at diagnosis |
|-------------------------|--|---|
| Prostate cancer: | <input type="radio"/> Father | <input type="text"/> <input type="text"/> |
| | <input type="radio"/> One brother | <input type="text"/> <input type="text"/> |
| | <input type="radio"/> Additional brother | <input type="text"/> <input type="text"/> |
| | <input type="radio"/> Additional brother | <input type="text"/> <input type="text"/> |
| | <input type="radio"/> Son | <input type="text"/> <input type="text"/> |
| | <input type="radio"/> None of the Above | <input type="text"/> <input type="text"/> |

| | | |
|---|---|---|
| Colon or Rectal cancer: | <input type="radio"/> Mother | <input type="text"/> <input type="text"/> |
| | <input type="radio"/> Father | <input type="text"/> <input type="text"/> |
| | <input type="radio"/> One sister | <input type="text"/> <input type="text"/> |
| | <input type="radio"/> Additional sister | <input type="text"/> <input type="text"/> |
| | <input type="radio"/> One brother | <input type="text"/> <input type="text"/> |
| | <input type="radio"/> Additional brother | <input type="text"/> <input type="text"/> |
| | <input type="radio"/> Daughter | <input type="text"/> <input type="text"/> |
| | <input type="radio"/> Son | <input type="text"/> <input type="text"/> |
| <input type="radio"/> None of the Above | <input type="text"/> <input type="text"/> | |

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