



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 past participation in the American Cancer Society's Cancer Prevention Study!

We hope you will take the time to complete and return this **very brief** questionnaire. Your participation and prompt response are critical to the accuracy of the results from this important study. Study results are valuable to cancer researchers and to the many people who turn to the American Cancer Society as one of the nation's most trusted cancer resources.◆

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.

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 fill in this square 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 fill in this square. →

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

Please answer the following questions by filling in the square or placing an X in the square of the response which most clearly represents your answer.

Correct

Correct

If you wish to change an answer, fill in the square or place an X for your preferred answer, and circle that preferred square.

→

Please PRINT where applicable. Enter only one letter or number per box.

C P S 2

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 Fair
 Very Good Poor
 Good

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

Pounds

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

No Yes

6. Do you usually use a cane or walker?

No Yes

7. Do you have difficulty with your balance?

No Yes

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

None 4
 1 5-9
 2 10 or more
 3

9. 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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colonoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sigmoidoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A prostate biopsy or rectal ultrasound for prostate examination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PSA blood test for prostate cancer screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL

10. 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

11. 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 10 or 11.**

12. 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



MISCELLANEOUS

13. <u>During the past year</u> , 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="checkbox"/>	<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="checkbox"/>	<input type="text"/>	→ <input type="text"/>
Ibuprofen <i>for example:</i> Motrin, Advil, Nuprin, Mediprin, etc.	<input type="checkbox"/>	<input type="text"/>	→ <input type="text"/>
COX2 inhibitors <i>for example:</i> Celebrex (celecoxib), Vioxx (rofecoxib), Bextra (valdecoxib), etc.	<input type="checkbox"/>	<input type="text"/>	→ <input type="text"/>
Acetaminophen <i>for example:</i> Tylenol, Phenaphen, etc.	<input type="checkbox"/>	<input type="text"/>	→ <input type="text"/>
Naprosyn (naproxen)	<input type="checkbox"/>	<input type="text"/>	→ <input type="text"/>
Other anti-inflammatory analgesics <i>for example:</i> Anaprox, Aleve, Voltaren, Feldene, Clinoril, Indocin, etc.	<input type="checkbox"/>	<input type="text"/>	→ <input type="text"/>

14. 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="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Moderate activities</i> , such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting or carrying groceries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing <i>several</i> flights of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing <i>one</i> flight of stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending, kneeling, or stooping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking <i>more than a mile</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking <i>several blocks</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking <i>one block</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bathing or dressing yourself	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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