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 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!

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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.

CPS2

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	☐	☐	☐
Mammogram	☐	☐	☐
Pap smear	☐	☐	☐
Colonoscopy	☐	☐	☐
Sigmoidoscopy	☐	☐	☐

10. 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 ☐ 6-9
☐ 3-5 ☐ 10 or more

MEDICAL

11. 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

- ☐ 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

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

Breast cancer

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

Cancer of the uterus or endometrium

- ☐ 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 11 or 12.***

13. Since August 2003, have you used prescription female replacement hormones?

- ☐ No
- ☐ 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

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

☐ Estrogen only ☐ Estrogen and Progesterone ☐ Other

MISCELLANEOUS

14. **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.	☐	☐ →	☐

15. 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	☐	☐	☐

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

Questar/Eagan, MN/Q50117C-CPS-II-Women-S