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!

To continue our contribution to cancer research, we must periodically update information regarding your lifestyle, screening practices, and use of medications/vitamins. We hope you will take the time to carefully complete this 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

BEFORE TURNING TO THE QUESTIONNAIRE, PLEASE READ THE BOXES BELOW.

If the person whose name appears on this form **has died**, please mark this square and **STOP HERE**. Return the blank questionnaire in the postage-paid envelope. → ☐

The answers to the following questions should be provided by the person named above. If someone else provides the answers **about that person**, please mark this square. → ☐

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: ____

☐

THANK YOU FROM THE EPIDEMIOLOGY STAFF OF THE AMERICAN CANCER SOCIETY

◆

INSTRUCTIONS

- Use a blue or black ink pen or dark pencil.
- Do not use felt tip markers or gel pens.
- 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. Stay within the confines of the box.

  → **Correct:** ☐■☐☐ **or** ☐☒☐☐

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

  → **Correct:** ◉☐■☐ **or** ⊗☐☒☐

- Please PRINT where applicable. Enter only one letter or number per box, and stay within the confines of the box. C P S 2
- **Please make an effort to fill out every question. If unsure, estimate to your best ability.**

GENERAL

3. What is your **current** marital status?

   ☐ Married ☐ Divorced
   ☐ Widowed ☐ Never married
   ☐ Separated

4. What is your **current** living arrangement?

   ☐ Alone ☐ Assisted living
   ☐ With spouse or partner ☐ Nursing home
   ☐ With other family ☐ Other

5. What is your **current** work status?

   ☐ Retired ☐ Volunteer
   ☐ Work full-time ☐ Disabled
   ☐ Work part-time

6. In general, would you say your health is:

   ☐ Excellent ☐ Fair
   ☐ Very Good ☐ Poor
   ☐ Good

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

   ☐☐☐ Pounds

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

   ☐ No
   ☐ Yes

   → How many per day?

   ☐ 1-4 cigarettes ☐ 25-34
   ☐ 5-14 ☐ 35-44
   ☐ 15-24 ☐ 45 or more

MEDICAL

9. 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 2005
- ☐ Aug. 2005 - July 2007
- ☐ After July 2007

Enlarged prostate, surgically treated

- ☐ Never
- ☐ Before August 2005
- ☐ Aug. 2005 - July 2007
- ☐ After July 2007

Benign polyp of the colon or rectum

- ☐ Never
- ☐ Before August 2005
- ☐ Aug. 2005 - July 2007
- ☐ After July 2007

Basal cell or squamous cell skin cancer

- ☐ Never
- ☐ Before August 2005
- ☐ Aug. 2005 - July 2007
- ☐ After July 2007

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

Prostate cancer

- ☐ Never
- ☐ Before August 2005
- ☐ Aug. 2005 - July 2007
- ☐ After July 2007

Lung or bronchial cancer

- ☐ Never
- ☐ Before August 2005
- ☐ Aug. 2005 - July 2007
- ☐ After July 2007

Colon or rectal cancer

- ☐ Never
- ☐ Before August 2005
- ☐ Aug. 2005 - July 2007
- ☐ After July 2007

Bladder cancer

- ☐ Never
- ☐ Before August 2005
- ☐ Aug. 2005 - July 2007
- ☐ After July 2007

Lymphoma

- ☐ Never
- ☐ Before August 2005
- ☐ Aug. 2005 - July 2007
- ☐ After July 2007

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

- ☐ Never
- ☐ Before August 2005
- ☐ Aug. 2005 - July 2007
- ☐ After July 2007

→ ***Specify other cancer not mentioned in questions 9 or 10.***

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

	Mark here for YES	Year first diagnosed: Before August 2005	August 2005-July 2007	After July 2007
Diabetes mellitus	☐	☐	☐	☐
Myocardial infarction (heart attack) or angina pectoris	☐	☐	☐	☐
Hospitalized for MI →	☐	☐	☐	☐
Coronary bypass, angioplasty or stent	☐	☐	☐	☐
Stroke (CVA) or TIA (Transient ischemic attack)	☐	☐	☐	☐
Carotid surgery (Endarterectomy)	☐	☐	☐	☐
Parkinson's Disease ◆	☐	☐	☐	☐
ALS (Lou Gehrig's Disease)	☐	☐	☐	☐
Emphysema or chronic bronchitis	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐
Wrist fracture, vertebral fracture or hip fracture	☐	☐	☐	☐
Osteoarthritis	☐	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐	☐

ALCOHOL

12. **On average**, how frequently did you drink any alcoholic beverage (beer, wine or liquor) in the last year?

☐ Never or less than 1 day per month
☐ 1-4 days per month
☐ 2-5 days per week
☐ 6-7 days per week

13. **On days that you drink**, how many drinks of alcohol (beer, wine or liquor) do you have on average?

☐ I don't drink alcohol
☐ 1 drink per day
☐ 2 drinks per day
☐ 3 or more drinks per day

MEDICATIONS

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

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

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: Zetia (ezetimibe), Tricor (fenofibrate), Gemfibrozil (Lopid), Questran (cholestyramine)

15. 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:* Norvasc, Cartia, amlodipine, verapamil, diltiazem, nifedipine	☐	☐
Beta Blocker	*for example:* Toprol, Coreg, atenolol, metoprolol, carvedilol	☐	☐
ACE Inhibitor	*for example:* Altace, lisinopril, enalapril, ramipril, quinapril, benazepril	☐	☐
Angiotensin II Receptor Blocker (ARB)	*for example:* Diovan, Cozaar, Avapro, Benicar, Atacand, valsartan, losartan, irbesartan, olmesartan, candesartan	☐	☐
Diuretic	*for example:* Lasix, hydrochlorothiazide, triamterene, furosemide, indapamide	☐	☐
Other	*(Mark here if unsure of heart or blood pressure medication category.)*	☐	☐
FOR URINARY SYMPTOMS OR OTHER REASONS:			
Viagra, Levitra, Cialis		☐	☐
Finasteride, Dutasteride	*for example:* Proscar, Propecia, Avodart	☐	☐
Alpha Blocker	*for example:* Flomax, Cardura, Hytrin, Minipress, (terazosin, doxazosin, tamsulosin, prazosin)	☐	☐
Other	*for example:* Detrol, Ditropan, Enablex	☐	☐
FOR DIABETES OR BLOOD SUGAR:			
Insulin injection or pump		☐	☐
Oral medications		☐	☐
BLOOD THINNERS	*for example:* Coumadin (warfarin), Plavix (clopidogrel)	☐	☐
THYROID MEDICATIONS	*for example:* Synthroid, Levoxyl, Levothroid, Levo-T, (levothyroxine, L-thyroxine)	☐	☐

16. **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)		☐	☐	→	☐
Regular or extra strength aspirin (163 mg or more)	*for example:* Bufferin, Anacin, Bayer, Excedrin, Ecotrin	☐	☐	→	☐
Ibuprofen	*for example:* Motrin, Advil, Nuprin, Mediprin	☐	☐	→	☐
Acetaminophen	*for example:* Tylenol, Phenaphen	☐	☐	→	☐
Naproxen	*for example:* Aleve, Naprosyn, Anaprox	☐	☐	→	☐
Other anti-inflammatory analgesics	*for example:* Mobic, nabumetone, diclofenac, indomethacin	☐	☐	→	☐
Celebrex		☐	☐	→	☐

Amount in **each** Celebrex pill
☐ 100 mg ☐ 200 mg ☐ 400 mg

EXERCISE

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

- ☐ Slow (less than 2 mph)
- ☐ Normal, average (2 to 2.9 mph)
- ☐ Brisk (3 to 3.9 mph)
- ☐ Very brisk, striding (4 mph or faster)
- ☐ Unable to walk

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	1-19 min	20-59 min	1 hr	1-1.5 hr	2-3 hr	4-6 hr	7-10 hr	11+ hrs
Walking (such as on treadmill, at golf)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bicycling/Stationary bike	☐	☐	☐	☐	☐	☐	☐	☐	☐
Jogging/Running, Lap Swimming, Tennis, Racquetball	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other aerobic exercise (such as elliptical or stair machine, aerobics, dancing)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Gardening, Mowing, Planting	☐	☐	☐	☐	☐	☐	☐	☐	☐
Weight training or resistance exercises (such as free weights or machines like Nautilus)	☐	☐	☐	☐	☐	☐	☐	☐	☐

19. **During the past year**, what was your **average total time per day** spent sitting or lying down during the day?

	None	Average Total Time Per Day: <15 min	15-29 min	30-59 min	60-89 min	1.5-<3 hrs	3-4 hrs	5-6 hrs	7+ hrs
Sitting or lying watching TV, VCR or DVD	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other sitting or lying (such as driving, reading, at desk or games)	☐	☐	☐	☐	☐	☐	☐	☐	☐

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
***Moderate activities*, such as moving a table, pushing a vacuum cleaner, bowling or playing golf**	☐	☐	☐
Climbing *one* flight of stairs	☐	☐	☐
Bending, kneeling or stooping	☐	☐	☐
Walking *several* blocks	☐	☐	☐

21. Do you usually use a cane or walker?

☐ No ☐ Yes

22. Do you have difficulty with your balance? ◆

☐ No ☐ Yes

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

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

SCREENING

24. 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	☐	☐	☐
PSA blood test for prostate cancer screening	☐	☐	☐

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

Colonoscopy: A long tube was inserted into the rectum to examine the entire colon for cancer or other problems. A medicine was given through a needle in your arm to make you sleepy and someone else needed to drive you home. Not the same as a sigmoidoscopy.

Sigmoidoscopy: A short tube was inserted into the rectum to examine the lower part of the colon to check for cancer or other problems. You were awake and not given a medicine to make you sleepy. You were probably able to drive yourself home.

VITAMINS

Multi-vitamins contain 10 or more vitamins and/or minerals. (For example: One-A-Day and Centrum)

25. 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

◆

26. **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
Glucosamine	☐ No ☐ Yes →		☐ 400 mg or less	☐ 500 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 64735, St. Paul, MN 55164-9836

Questar/Eagan, MN Q70057C-Men-L