



# 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!

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 ☐ Homemaker  
☐ Work part-time ☐ Disabled

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

# WOMEN'S HEALTH ISSUES

9. SINCE AUGUST 2005, have you used **prescription** female replacement hormones?

☐ No (*Go to Question 10*)

☐ Yes



a. Are you **currently** using them (within the last month)?

☐ Yes, currently

☐ No, not currently (*If no, go to Question 10*)

b. Mark the type(s) of hormones you are **currently** using:

☐ Combined estrogen and progestin (in a single pill or patch, or in two pills)

☐ Estrogen alone (in pill or patch)

☐ Vaginal estrogen alone (in cream, tablet or ring)

☐ Other

## 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.)

**Fibrocystic or other  
benign breast disease**

☐ 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

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

**Breast cancer**

☐ Never

☐ Before August 2005

☐ Aug. 2005 - July 2007

☐ After July 2007

**Cancer of the uterus  
or endometrium**

☐ 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 10 or 11.

12. 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 (except during pregnancy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Myocardial infarction (heart attack) or angina pectoris	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalized for MI 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coronary bypass, angioplasty or stent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke (CVA) or TIA (Transient ischemic attack)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Carotid surgery (Endarterectomy)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Parkinson's Disease 	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
ALS (Lou Gehrig's Disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema or chronic bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wrist fracture, vertebral fracture or hip fracture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoarthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### ALCOHOL

13. **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
 ☐ 2-5 days per week  
☐ 1-4 days per month
 ☐ 6-7 days per week
14. **On days that you drink**, how many drinks of alcohol (beer, wine or liquor) do you have on average?
- ☐ I don't drink alcohol
 ☐ 2 drinks per day  
☐ 1 drink per day
 ☐ 3 or more drinks per day

# MEDICATIONS

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

- |  |   |
|--|---|
| <input type="checkbox"/> Fosamax (alendronate) | <input type="checkbox"/> Calcimar, Cibacalcin, Miacalcin (calcitonin) |
| <input type="checkbox"/> Actonel (risedronate) | <input type="checkbox"/> Didronel (etidronate)                        |
| <input type="checkbox"/> Boniva (ibandronate)  | <input type="checkbox"/> Forteo injections (teriparatide)             |

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

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Lipitor (atorvastatin) | <input type="checkbox"/> Lovastatin (Mevacor or Altoprev) | <input type="checkbox"/> Crestor (rosuvastatin)            |
| <input type="checkbox"/> Zocor (simvastatin)    | <input type="checkbox"/> Pravachol (pravastatin)          | <input type="checkbox"/> Lescol or Lescol XL (fluvastatin) |

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

- |                               |                                |                                |                                |                                |                                |
|-------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> 5 mg | <input type="checkbox"/> 10 mg | <input type="checkbox"/> 20 mg | <input type="checkbox"/> 40 mg | <input type="checkbox"/> 60 mg | <input type="checkbox"/> 80 mg |
|-------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|--------------------------------|

- ☐ Caduet
- ☐ Vytorin
- ☐ Any other cholesterol-lowering drug not listed above, for example: Zetia (ezetimibe), Tricor (fenofibrate), Gemfibrozil (Lopid), Questran (cholestyramine)

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

	No	Yes
<b>FOR HEART OR BLOOD PRESSURE:</b>		
<b>Calcium Blocker</b> <i>for example: Norvasc, Cartia, amlodipine, verapamil, diltiazem, nifedipine</i>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Beta Blocker</b> <i>for example: Toprol, Coreg, atenolol, metoprolol, carvedilol</i>	<input type="checkbox"/>	<input type="checkbox"/>
<b>ACE Inhibitor</b> <i>for example: Altace, lisinopril, enalapril, ramipril, quinapril, benazepril</i>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Angiotensin II Receptor Blocker (ARB)</b> <i>for example: Diovan, Cozaar, Avapro, Benicar, Atacand, valsartan, losartan, irbesartan, olmesartan, candesartan</i>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Diuretic</b> <i>for example: Lasix, hydrochlorothiazide, triamterene, furosemide, indapamide</i>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Other</b> <i>(Mark here if unsure of heart or blood pressure medication category.)</i>	<input type="checkbox"/>	<input type="checkbox"/>
<b>FOR DIABETES OR BLOOD SUGAR:</b>		
<b>Insulin injection or pump</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Oral medications</b>	<input type="checkbox"/>	<input type="checkbox"/>
<b>BLOOD THINNERS</b> <i>for example: Coumadin (warfarin), Plavix (clopidogrel)</i>	<input type="checkbox"/>	<input type="checkbox"/>
<b>THYROID MEDICATIONS</b> <i>for example: Synthroid, Levoxyl, Levothroid, Levo-T, (levothyroxine, L-thyroxine)</i>	<input type="checkbox"/>	<input type="checkbox"/>
<b>TAMOXIFEN</b> <i>for example: Nolvadex</i>	<input type="checkbox"/>	<input type="checkbox"/>
<b>RALOXIFENE</b> <i>for example: Evista</i>	<input type="checkbox"/>	<input type="checkbox"/>
<b>ARIMIDEX, FEMARA OR AROMASIN (EXEMESTANE)</b>	<input type="checkbox"/>	<input type="checkbox"/>

18. **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
<b>Aspirin</b>			<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Baby or low-dose aspirin (162 mg or less)				→	
Regular or extra strength aspirin (163 mg or more)	<i>for example:</i>	Bufferin, Anacin, Bayer, Excedrin, Ecotrin	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
				→	
<b>Ibuprofen</b>			<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
	<i>for example:</i>	Motrin, Advil, Nuprin, Mediprin		→	
<b>Acetaminophen</b>			<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
	<i>for example:</i>	Tylenol, Phenaphen		→	
<b>Naproxen</b>			<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
	<i>for example:</i>	Aleve, Naprosyn, Anaprox		→	
<b>Other anti-inflammatory analgesics</b>			<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
	<i>for example:</i>	Mobic, nabumetone, diclofenac, indomethacin		→	
<b>Celebrex</b>			<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
				→	

Amount in **each** Celebrex pill

☐ 100 mg    ☐ 200 mg    ☐ 400 mg

## EXERCISE

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

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

20. **During the past year**, what was your **average total time per week** spent at each of the following activities?

[illegible]

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

Average Total Time Per Day

	None	<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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other sitting or lying (such as driving, reading, at desk or games)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

22. 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing one 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 several blocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

23. Do you usually use a cane or walker?

☐ No ☐ Yes

24. Do you have difficulty with your balance?

☐ No ☐ Yes

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

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

## SCREENING

26. 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"/>
Mammogram	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pap smear	<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"/>

**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)

27. 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

28. **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.)

	<input type="checkbox"/> No <input type="checkbox"/> Yes →	Pills Per Week	→	Amount in Each Pill		
<b>Vitamin A</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="text"/>	→	<input type="checkbox"/> 7,500 IU or less	<input type="checkbox"/> 8,000 IU or more	<input type="checkbox"/> Don't know
<b>Beta Carotene</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="text"/>	→	<input type="checkbox"/> 12,000 IU or less	<input type="checkbox"/> 13,000 IU or more	<input type="checkbox"/> Don't know
<b>Vitamin C</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="text"/>	→	<input type="checkbox"/> 450 mg or less	<input type="checkbox"/> 500 mg or more	<input type="checkbox"/> Don't know
<b>Vitamin E</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="text"/>	→	<input type="checkbox"/> 250 IU or less	<input type="checkbox"/> 300 IU or more	<input type="checkbox"/> Don't know
<b>Selenium</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="text"/>	→	<input type="checkbox"/> 135 mcg or less	<input type="checkbox"/> 140 mcg or more	<input type="checkbox"/> Don't know
<b>Folic Acid</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="text"/>	→	<input type="checkbox"/> 300 mcg or less	<input type="checkbox"/> 350 mcg or more	<input type="checkbox"/> Don't know
<b>Vitamin B<sub>6</sub></b>	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="text"/>	→	<input type="checkbox"/> 35 mg or less	<input type="checkbox"/> 40 mg or more	<input type="checkbox"/> Don't know
<b>Vitamin B<sub>12</sub></b>	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="text"/>	→	<input type="checkbox"/> 200 mcg or less	<input type="checkbox"/> 250 mcg or more	<input type="checkbox"/> Don't know
<b>Niacin</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="text"/>	→	<input type="checkbox"/> 300 mg or less	<input type="checkbox"/> 400 mg or more	<input type="checkbox"/> Don't know
<b>Calcium</b> (Include Calcium in Tums, etc.) (1 Tums = 200 mg elemental calcium)	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="text"/>	→	<input type="checkbox"/> 350 mg or less	<input type="checkbox"/> 400 mg or more	<input type="checkbox"/> Don't know
<b>Vitamin D</b> (In Calcium supplement or separately)	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="text"/>	→	<input type="checkbox"/> 350 IU or less	<input type="checkbox"/> 400 IU or more	<input type="checkbox"/> Don't know
<b>Zinc</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="text"/>	→	<input type="checkbox"/> 45 mg or less	<input type="checkbox"/> 50 mg or more	<input type="checkbox"/> Don't know
<b>Glucosamine</b>	<input type="checkbox"/> No <input type="checkbox"/> Yes →	<input type="text"/>	→	<input type="checkbox"/> 400 mg or less	<input type="checkbox"/> 500 mg or more	<input type="checkbox"/> 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