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.
- 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, and stay within the confines of the box.
- Please make an effort to fill out every question. If unsure, estimate to your best ability.

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.)
   - A physical exam
   - Yes, for routine exams
   - Yes, for symptoms
   - Colonoscopy
   - Yes
   - No
   - Sigmoidoscopy
   - Yes
   - No
   - A prostate biopsy
   - Yes
   - No
   - PSA blood test for prostate cancer screening
   - Yes
   - No

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

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
    - Enlarged prostate, surgically treated
      - Never
      - Before August 2005
      - After July 2007

11. Has a physician ever told you that you had any of the following cancers?
    - Prostate cancer
    - Lung or bronchial cancer
    - Basal cell or squamous cell skin cancer
      - Never
      - Before August 2005
      - After July 2007

12. Multi-vitamins contain 10 or more vitamins and/or minerals. (For example: One-A-Day and Centrum)
    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
13. 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.)

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<thead>
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<tbody>
<tr>
<td>Diabetes mellitus</td>
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<td>Myocardial infarction (heart attack) or angina pectoris</td>
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<td>Hospitalized for MI</td>
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<td>Coronary bypass, angioplasty or stent</td>
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<td>Stroke (CVA) or TIA (Transient ischemic attack)</td>
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<td>Carotid surgery (Endarterectomy)</td>
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<td>Parkinson's Disease</td>
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<td>ALS (Lou Gehrig’s Disease)</td>
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<td>Emphysema or chronic bronchitis</td>
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<td>Osteoporosis</td>
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<td>Wrist fracture, vertebral fracture or hip fracture</td>
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14. During the past year, on average, how frequently have you taken the following?

- Aspirin (Baby or low-dose aspirin (162 mg or less))
- Regular or extra strength aspirin (163 mg or more)
- Ibuprofen
- Acetaminophen
- Naproxen
- Other anti-inflammatory analgesics
- Celebrex

Never, or less than once a month

At least once a month, days per month, pills per day

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Dear Cancer Prevention Study Participant,

Thank you for your past participation in the 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 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
   - Yes

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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.