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. 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)

    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

WOMEN'S HEALTH ISSUES

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

    ☐ No (***Go to Question 12***)
    ☐ Yes →
    a. Are you **currently** using them (within the last month)?
    ☐ Yes, currently ☐ No, not currently (***If no, go to Question 12***)
    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

12. 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	Benign polyp of the colon or rectum	Basal cell or squamous cell skin cancer
☐ Never	☐ Never	☐ Never
☐ Before August 2005	☐ Before August 2005	☐ Before August 2005
☐ Aug. 2005 - July 2007	☐ Aug. 2005 - July 2007	☐ Aug. 2005 - July 2007
☐ After July 2007	☐ After July 2007	☐ After July 2007

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

Breast cancer	Cancer of the uterus or endometrium	Lung or bronchial cancer
☐ Never	☐ Never	☐ Never
☐ Before August 2005	☐ Before August 2005	☐ Before August 2005
☐ Aug. 2005 - July 2007	☐ Aug. 2005 - July 2007	☐ Aug. 2005 - July 2007
☐ After July 2007	☐ After July 2007	☐ After July 2007

Colon or rectal cancer	Bladder cancer	Lymphoma
☐ Never	☐ Never	☐ Never
☐ Before August 2005	☐ Before August 2005	☐ Before August 2005
☐ Aug. 2005 - July 2007	☐ Aug. 2005 - July 2007	☐ Aug. 2005 - July 2007
☐ After July 2007	☐ After 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 12 or 13.***

14. 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)	☐	☐	☐	☐
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	☐	☐	☐	☐

15. **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		☐	→	

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-Women-S

American Cancer Society®

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 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 →
   - ☐ No, my birth state is: ___

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