



MEN

If this is not your full **LEGAL** name and mailing address, please make changes on this page.

Dear Cancer Prevention Study Participant,

We hope you will take the time to complete and return this **very brief** questionnaire. Your participation and prompt response are critical to the Cancer Prevention Study. Study results are valuable not only to cancer researchers but also to the many people who turn to the American Cancer Society as one of the nation's most trusted cancer resources.

Also, 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,

Susan M. Gapstur, PhD, MPH
Vice President of Epidemiology

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

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.

↳ Correct: ■□□□ or ☒□□□ or PRINT where applicable: C P S 2

- To change an answer, fill in the square and **circle** the square of your preferred answer.

↳ Correct: ●□■□ or ⊗□⊗□

MEDICAL

2. Has a physician ever told you that you had any of the following **conditions** or **cancers**?
(If not, mark **No**; if yes, mark year **first** diagnosed.)

	NO	Year first diagnosed		
		BEFORE AUGUST 2007	AUG 2007 TO JULY 2009	AFTER JULY 2009
Enlarged prostate, <u>not</u> surgically treated →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged prostate, surgically treated →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Benign polyp of the colon or rectum →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Basal cell or squamous cell skin cancer →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prostate cancer →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung or bronchial cancer →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon or rectal cancer →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder cancer →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lymphoma →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other cancer →	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(Specify type of other cancer) →	<div style="border: 1px solid black; width: 100%; height: 20px; background-color: #e0e0e0;"></div>			

3. In the **past two years**, have you used the medications Finasteride (Proscar, Propecia) or Dutasteride (Avodart) on a **regular** basis?

- No Yes

GENERAL HEALTH

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

- Excellent
- Very Good
- Good
- Fair
- Poor

5. In general, would you say your quality of life is:

- Excellent
- Very Good
- Good
- Fair
- Poor

6. In general, how would you rate your physical health?

- Excellent
- Very Good
- Good
- Fair
- Poor

7. In general, how would you rate your mental health, including your mood and your ability to think?

- Excellent
- Very Good
- Good
- Fair
- Poor

8. In general, how would you rate your satisfaction with your social activities and relationships?

- Excellent
- Very Good
- Good
- Fair
- Poor

9. How would you rate your pain on average?

- 0 = No Pain
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 = Worst pain imaginable

10. How would you rate your fatigue on average?

- None
- Mild
- Moderate
- Severe
- Very Severe

11. How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?

- Never
- Rarely
- Sometimes
- Often
- Always

12. To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?

- Completely
- Mostly
- Moderately
- A little
- Not at all

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

Pounds

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

- No
- Yes

15. 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"/>
Colonoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sigmoidoscopy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A prostate biopsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PSA blood test for prostate cancer screening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If "yes" for PSA screening, was your PSA elevated?

- No
- Unknown
- Yes

16. 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 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

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

18. 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 2007	August 2007- July 2009	After July 2009
Diabetes mellitus	<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 or Rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 55164-9881