AMERICAN CANCER SOCIETY **CANCER PREVENTION STUDY II** **QUESTIONNAIRE FOR MEN** 	Division No.	Unit No.	Group No.
	Researcher No.	Family No.	Person No.

Date: _____

1. Name: _____
2. Date of birth: Month _____ Year _____
3. How old are you now? _____
4. Current weight with indoor clothing: _____ lbs.
5. Weight 1 year ago: _____ lbs.
6. Height (without shoes): _____ ft. _____ in.
7. ☐ White ☐ Black ☐ Hispanic ☐ Oriental ☐ Other _____ (specify)
8. Marital status: ☐ Single ☐ Separated ☐ Widowed ☐ Married ☐ Divorced
9. If ever married, age at first marriage: _____
10. Number of times married: _____
11. Social Security No.: _____ (optional)

FAMILY HISTORY (IN RELATION TO CANCER):

1. Fill in the following table as completely as possible for parents, brothers and sisters.

LIST ONE BLOOD RELATIVE PER LINE: (Circle Brother **or** Sister)	IS THIS PERSON? (Circle One)	IF ALIVE, GIVE AGE	IF DEAD, GIVE AGE AT DEATH	DID THIS PERSON **EVER** HAVE CANCER? (Circle One)	IF "YES," SPECIFY TYPE OF CANCER	AT WHAT AGE?
Father	Alive Dead			Yes No		
Mother	Alive Dead			Yes No		
Brother or Sister	Alive Dead			Yes No		
Brother or Sister	Alive Dead			Yes No		
Brother or Sister	Alive Dead			Yes No		
Brother or Sister	Alive Dead			Yes No		
Brother or Sister	Alive Dead			Yes No		
Brother or Sister	Alive Dead			Yes No		

2. When you were born, a) How old was your mother? _____ b) How old was your father? _____

HISTORY OF DISEASES:

1. Have you ever had cancer? ☐ Yes ☐ No. If "yes,"
   a) What type? _____
   b) Date of first treatment: _____
2. Place a check-mark by the following diseases or conditions for which you have ever been diagnosed by a doctor:
   - ☐ High Blood Pressure
   - ☐ Heart Disease
   - ☐ Stroke
   - ☐ Diabetes
   - ☐ Gall Stones
   - ☐ Chronic Indigestion
   - ☐ Kidney Disease
   - ☐ Kidney Stones
   - ☐ Bladder Disease
   - ☐ Cirrhosis of the Liver
   - ☐ Tuberculosis
   - ☐ Chronic Bronchitis
   - ☐ Emphysema
   - ☐ Hay Fever
   - ☐ Asthma
   - ☐ Stomach Ulcer
   - ☐ Duodenal Ulcer
   - ☐ Diverticulosis
   - ☐ Rectal Polyps
   - ☐ Colon Polyps
   - ☐ Thyroid Condition
   - ☐ Arthritis
   - ☐ Prostate Trouble
   - ☐ Hepatitis
   - ☐ Any other serious disease (specify) _____
3. Have you ever had an operation? ☐ Yes ☐ No
   If "yes," specify type and date(s) of operation(s):
   _____
   _____
   _____
4. How **many** x-ray or fluoroscopic **examinations** (GI series, barium enema, etc.) have you **ever** had of:

	0	1-5	6 or More		0	1-5	6 or More
Stomach	☐	☐	☐	Chest	☐	☐	☐
Intestine	☐	☐	☐	Arms/Legs	☐	☐	☐
Back	☐	☐	☐	Head/Neck	☐	☐	☐

5. Have you ever been **treated** with radium, x-rays, or radioactive isotopes? ☐ Yes ☐ No
   If "yes," when? _____
   For what disease? _____
   _____
   What part of your body? _____
   _____
6. How many times have you had colds or flu in the past twelve months? _____

CURRENT PHYSICAL CONDITION:

1. How much exercise do you get (work or play)?
   ☐ None ☐ Slight ☐ Moderate ☐ Heavy
2. On the average, how many hours do you sleep each night? _____
3. On the average, how many times a month do you have insomnia? _____ ☐ None
4. Within the last month, have you noticed:
   a) Painful or frequent urination? ☐ Yes ☐ No
   b) An unusual discharge from your penis? ☐ Yes ☐ No
5. Do you notice pains in your legs when you walk which go away when you rest? ☐ Yes ☐ No
   If "yes," how many years have you had these pains? _____
6. Are you sick at the present time? ☐ Yes ☐ No
   If "yes," with what disease or condition? _____

HABITS:

1. **Whether or not you smoke,** on the average, how many **hours a day** are you exposed to cigarette smoke of others:
   At home_____, At work_____, In other areas_____.
2. Do you now or have you ever smoked cigarettes, cigars or pipes, at least one a day for one year's time? ☐ Yes ☐ No
   If never smoked, skip to question 8.
3. If you **currently** smoke cigarettes, cigars or pipes, fill in the information below:

Current Smokers	Cigarettes	Cigars	Pipes
Average number smoked per day			
Age began smoking			
INHALATION:			
Do not inhale			
Inhale slightly			
Inhale moderately			
Inhale deeply			
Total years of smoking			
Years smoked **filtered** cigarettes			
Years smoked **non-filtered** cigarettes			

4. Current brand of cigarette: _____
   a) Size: ☐ Regular ☐ King ☐ 100 mm ☐ 120 mm
   b) ☐ Non-filter ☐ Filter ☐ Menthol
   c) Years smoked this brand: _____

5. If you have **quit** smoking cigarettes, cigars or pipes, fill in the information below:

Ex-Smokers	Cigarettes	Cigars	Pipes
Average number smoked per day			
Age began smoking			
Age quit			
INHALATION:			
Did not inhale			
Inhaled slightly			
Inhaled moderately			
Inhaled deeply			
Total years smoked			
Years smoked **filtered** cigarettes			
Years smoked **non-filtered** cigarettes			

6. Last brand of cigarette smoked: _____
   a) Size: ☐ Regular ☐ King ☐ 100 mm ☐ 120 mm
   b) ☐ Non-filter ☐ Filter ☐ Menthol
   c) Years smoked this brand: _____

7. Current **and** ex-cigarette smokers, fill in the following information for:
   1) The **first** brand smoked **regularly; and**
   2) The brand of cigarette smoked for the **longest** period of time.

Brand Name	Size	Filter		Menthol		Number Per Day	Years
		Yes	No	Yes	No		
1.							
2.							

8. Have you ever chewed tobacco at least once a week for at least one year? ☐ Yes ☐ No
   If "no," skip to question 9.
   a) Age began chewing tobacco: _____
   b) How many times a week? _____
   c) For how many years? _____
   d) Do you still chew tobacco? ☐ Yes ☐ No

9. Have you ever used snuff at least once a week for at least one year? ☐ Yes ☐ No
   If "no," skip to "Diet."
   a) Age began using snuff: _____
   b) How many times a week? _____
   c) For how many years? _____
   d) Do you still use snuff? ☐ Yes ☐ No

DIET:

1. On the average, how many days per week do you eat the following foods? (If less than once a week, but at least twice a month, write 1/2.)

Beef_____
Pork_____
Chicken_____
Liver_____
Ham_____
Fish_____
Smoked meats_____
Frankfurters/ Sausage_____
Butter_____
Margarine_____
Cheese_____
Eggs_____
Green leafy vegetables_____
Tomatoes_____
Cabbage/Broccoli/ Brussels sprouts_____
Raw vegetables_____
Carrots_____
Squash/Corn_____
Citrus fruits/Juices_____
Spaghetti/Macaroni/ White rice_____
White bread/Rolls/ Biscuits_____
Brown rice/Whole wheat/Barley_____
Bran/Corn muffins_____
Potatoes_____
Oatmeal/Shredded wheat/Bran cereals_____
Cold (Dry) cereals_____
Ice cream_____
Chocolate_____

2. How many days a week do you eat the following **fried** foods?

Fried eggs_____
Fried bacon_____
Fried chicken/fish_____
French fries_____
Fried hamburgers or beef_____
Other fried foods_____
DO NOT EAT FRIED FOODS ☐

3. Do you eat a vegetarian diet? ☐ Yes ☐ No
If "yes," what type and for how many years?_____

4. Has there been a major change in your diet in the last 10 years? ☐ Yes ☐ No
If "yes," what was the change?_____

5. a) Do you now or have you ever added artificial sweeteners (saccharin or cyclamates) to coffee, tea, or other drinks or food?
☐ Yes, currently ☐ Formerly ☐ Never
b) If **ever** used artificial sweeteners, indicate amount per day and for how long.
Packets: No. per day_____ Years_____
Drops: No. per day_____ Years_____
Tablets: No. per day_____ Years_____

6. Do you get your drinking water from: ☐ City supply ☐ Private well ☐ Other (specify)_____

7. Do you add any substances to soften your drinking water? ☐ Yes ☐ No

8. How many cups, glasses, or drinks of these beverages do you usually drink a day, and for how many years? (If you no longer drink a listed beverage, or your pattern has changed in the last ten years, indicate previous and current amounts. If less than once a day, but at least three times a week, write 1/2.)

Beverages	Currently		Previously	
	Amount	Years	Amount	Years
Whole milk (not skim milk)				
Caffeinated coffee				
Decaffeinated coffee				
Tea				
Diet soda or diet iced tea				
Non-diet colas				
Other non-diet soft drinks				
Beer				
Wine				
Hard liquor				

MEDICATIONS AND VITAMINS:

1. How many times in the last month have you used the following and how long have you used them? (If none, write 0; if used only occasionally, write 1/2.)

Medications and Vitamins	Times	Years
Aspirin, Bufferin, Anacin		
Tylenol		
Vitamin A		
Vitamin C		
Vitamin E		
Multi-Vitamins		
Blood Pressure pills		
Diuretics (water pills)		
Thyroid medications		
Heart medications		
Anti-Acid medications		
Valium		
Librium		
Prescription sleeping pills		
Tagamet (for ulcers)		
Other: _____		
_____		

OCCUPATIONS:

1. What is your current occupation and what are your duties? _____
   _____
   _____ How many years: _____
2. If retired, what was your last occupation? _____
   _____
   _____
   _____ Year retired: _____
3. What other job have you held for the longest period of time? _____
   _____
   _____ How many years: _____
4. What time of day do you start working? _____
   Do you work rotating shifts? ☐ Yes ☐ No
5. How many hours a week do you work on:
   paid jobs _____, volunteer work _____,
   housework _____.
6. In your work or daily life, are (were) you **regularly** exposed to any of the following? If "yes," indicate the number of years exposed.

Exposure to:	Check One		Number of Years
	Yes	No	
Asbestos			
Chemicals/Acids/Solvents			
Coal or Stone Dusts			
Coal Tar/Pitch/Asphalt			
Diesel Engine Exhaust			
Dyes			
Formaldehyde			
Gasoline Exhaust			
Pesticides/Herbicides			
Textile Fibers/Dusts			
Wood Dust			
X-rays/Radioactive Materials			

REMARKS:

MISCELLANEOUS:

1. Where were you born? _____ (city) _____ (state/country)
2. Where were your parents born?
   Father: _____
   Mother: _____
3. Religion: ☐ Protestant ☐ Catholic ☐ Jewish
   ☐ LDS ☐ Other _____ ☐ None
   If Protestant, what denomination? _____
4. Education:
   ☐ 8th Grade or Less ☐ Some College
   ☐ Some High School ☐ College Graduate
   ☐ High School Graduate ☐ Graduate School
   ☐ Vocational/Trade School
5. How many years have you lived in your present neighborhood? _____
6. How many friends or relatives do you feel close to? _____
7. How many times a month do you:
   a) Go to church or temple? _____
   b) Attend club meetings? _____
   c) Participate in group activities? _____
8. Were you in the U.S. Armed Services? ☐ Yes ☐ No
   If "yes,"
   a) What branch of the service were you in? _____
      _____
   b) What were your dates of service?
      _____ to _____,
      _____ to _____.
   c) Where did you serve? _____
      _____
9. What is the most upsetting event that happened to you in about the last five years? _____
   _____
   _____ ☐ None
10. Do you now or have you ever used mouthwash? ☐ Yes ☐ No
    If "yes,"
    a) What brand? _____
    b) How many times a week is it used? _____
    c) For how many years have you used it? _____