

AMERICAN CANCER SOCIETY

CANCER PREVENTION STUDY QUESTIONNAIRE FOR MEN

Division No. 1-2	Unit No. 3-5	Group No. 6-6
Researcher No. 9-11	Family No. 12-13	Person No. 14-15

1. Name: _____ 2. Date: 16 Spouse or Spouse's Death
 3. Date of Birth: Month: 17-18 5-19 Year: 19 4. Present Weight (Indoor clothing): _____ lbs.
 5. Height (Without shoes): _____ ft. _____ in. 6. Race: White Negro Indian Other: _____
 7. Marital Status: Single Married Widowed Divorced Separated

FAMILY HISTORY (IN RELATION TO CANCER): Please indicate for each of the following members of your family: whether living or dead; their present age or age at time of death; and whether or not they ever had cancer.

1. Your Parents and Grandparents:

- (a) Father: 31 Alive 50 Dead ; Age _____; Cancer: Yes No ; Type of Cancer: 22-23
 (b) Mother: Alive Dead ; Age 34 _____; Cancer: Yes No ; Type of Cancer: 37-38
 (c) Father's father: Alive Dead ; Age 37 (approximate): _____; Cancer: Yes No Don't know
 (d) Father's mother: Alive Dead ; Age 39 (approximate): _____; Cancer: Yes No Don't know
 (e) Mother's father: Alive Dead ; Age 41 (approximate): _____; Cancer: Yes No Don't know
 (f) Mother's mother: Alive Dead ; Age 43 (approximate): _____; Cancer: Yes No Don't know

2. Your Brothers: (Please list all of them, living or dead). - No of brothers - 45

- a) Alive or Dead ; Age 47 _____; Cancer: Yes No ; Type of Cancer: 48-49
 b) Alive or Dead ; Age _____; Cancer: Yes No ; Type of Cancer: 52-53
 c) Alive or Dead ; Age _____; Cancer: Yes No ; Type of Cancer: 56-57
 d) Alive or Dead ; Age _____; Cancer: Yes No ; Type of Cancer: 60-61
 e) Alive or Dead ; Age _____; Cancer: Yes No ; Type of Cancer: 62-63

3. Your Sisters: (Please list all of them, living or dead). - No of sisters - 74

- a) Alive or Dead ; Age 75 _____; Cancer: Yes No ; Type of Cancer: 77-78
 b) Alive or Dead ; Age 79 _____; Cancer: Yes No ; Type of Cancer: 81-82
 c) Alive or Dead ; Age _____; Cancer: Yes No ; Type of Cancer: 85-86
 d) Alive or Dead ; Age 87 _____; Cancer: Yes No ; Type of Cancer: 89-90
 e) Alive or Dead ; Age 91 _____; Cancer: Yes No ; Type of Cancer: 93-94
 f) Alive or Dead ; Age 95 _____; Cancer: Yes No ; Type of Cancer: 97-98

4. Do you (or did you) have a twin brother? Yes No If "yes," indicate above which brother.

5. When you were born: How old was your mother? 49 How old was your father? 100-101

HISTORY OF DISEASES:

1. Have you ever had cancer? Yes No
 If "yes," a) What type of cancer: 12-13 b) Date of first treatment: 1-4-10

2. Please make a check mark after the name of each of the following diseases you have ever had:
- Pneumonia Tuberculosis Bronchitis Influenza Laryngitis Tonsillitis
 Asthma Hay Fever Dysentery Stomach Ulcer Duodenal Ulcer Diabetes
 Heart Disease Stroke High Blood Pressure Rheumatic Fever Cirrhosis of Liver
 Gallstones Arthritis Poliomyelitis Goiter Enlarged Prostate

Any serious disease not listed above: (please specify): _____

3. How often have you had colds (or sniffles) in the last year? _____

162-176, 178 Blank for males

HABITS:

179 1. How much exercise do you get (work or play): None Slight Moderate Heavy

180 2. How many hours of sleep do you usually get a night? _____

181 3. Do you now smoke? Yes No

182 If "yes," a) How many cigarettes do you usually smoke a day? _____

b) How many cigars do you usually smoke a day? _____

183 c) How many pipefuls of tobacco do you usually smoke a day? _____

4. If you now smoke cigarettes:

184 a) About how much do you inhale when smoking cigarettes?
Do not inhale Inhale Slightly Inhale Moderately Inhale Deeply

185 b) What type do you smoke? Filter-tip Without filter-tip

c) What brand do you usually smoke? _____

186 d) How old were you when you started smoking cigarettes? _____

5. If you now smoke cigars, about how much do you inhale when smoking cigars?

184 Do Not Inhale Inhale Slightly Inhale Moderately Inhale Deeply

6. If you now smoke a pipe, about how much do you inhale when smoking a pipe?

184 Do Not Inhale Inhale Slightly Inhale Moderately Inhale Deeply

7. If you do not smoke cigarettes now, did you ever smoke cigarettes regularly? Yes No

If "yes," a) How long has it been since you last smoked cigarettes regularly? _____

b) How many cigarettes did you usually smoke per day? _____

c) Why did you stop smoking cigarettes? _____

187 8. If you do not smoke cigars now, did you ever smoke cigars regularly? Yes No

9. If you do not smoke a pipe now, did you ever smoke a pipe regularly? Yes No

188 10. Do you chew tobacco or use snuff? Never Occasionally Regularly

11. How many days a week do you eat each of the following foods?

Fish 18; Meat or poultry 19; Eggs 19; Cheese 17; Butter or oleomargarine 19;
Bread, rolls, or biscuits 19; Pancakes 19; Cereal 19; Spaghetti or macaroni 19;
Potatoes 19; Rice 19; Cooked vegetables 20; Green salads 19; Fruits or fruit juices 21;
Sweet desserts 19; Candy 19.

12. When eating meat, do you avoid eating the fat? Yes No

13. How many days a week do you eat each of the following fried foods:

Fried eggs _____; Fried bacon, fried sausage, or fried ham _____; Fried potatoes _____;
Fried chicken or fried fish _____; Other fried food _____.

14. Do you often add salt to your food? Yes No ; Pepper? Yes No

Catsup, mustard, or spices? Yes No ; Mayonnaise or salad oil? Yes No

15. Do you often eat: Bacon? Yes No ; Pork chops? Yes No ; Other Pork? Yes No

Frankfurters? Yes No ; Smoked or Salt fish? Yes No

16. How many cups, glasses, or "shots" of the following beverages do you usually take a day?

a) Milk 2; b) Coffee 1; c) Tea 1; d) Soft drinks 2;
e) Beer 1; f) Wine 1; g) Whiskey, gin, etc. 1.

17. When drinking coffee, tea, or soup, do you take it: Very hot Moderately hot Lukewarm

18. How often do you use the following types of medicine?

Aspirin, Bufferin... Never Seldom Often ; T. S. Quinine... Never Seldom Often
Vitamin pills... Never Seldom Often ; Laxatives... Never Seldom Often
Sleeping pills... Never Seldom Often ; Anesthetics... Never Seldom Often

4. Have you ever had a surgical operation? Yes No *Summary-129*

If "yes," please specify type of operation(s): 130-133

5. Have you ever had an X-ray or fluoroscopic examination of your stomach or abdomen? ¹³⁶ Yes No

6. Have you ever been treated with radium, X-rays, or radioactive isotopes? ¹³⁷ Yes No

If "yes," what part of your body? _____

What disease were you treated for? _____

PRESENT PHYSICAL COMPLAINTS: Please check "yes" or "no" after each complaint listed. If you check "yes," please indicate the severity of the condition.

1. ¹³⁸ <u>A Cough:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	10. ¹⁴⁴ <u>Blood in the Stool:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Seldom <input type="checkbox"/> Fairly Often <input type="checkbox"/> Often <input type="checkbox"/>	19. ¹⁴⁷ <u>Headaches:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Seldom <input type="checkbox"/> Fairly Often <input type="checkbox"/> Often <input type="checkbox"/>
2. ¹³⁹ <u>Sore Throat:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	11. ¹⁴⁴ <u>Pain or Discomfort in Lower Abdomen:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Seldom <input type="checkbox"/> Fairly Often <input type="checkbox"/> Often <input type="checkbox"/>	20. ¹⁴⁷ <u>Dizziness:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Seldom <input type="checkbox"/> Fairly Often <input type="checkbox"/> Often <input type="checkbox"/>
3. ¹³⁹ <u>Hoarseness:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	12. ¹⁴⁴ <u>Pain in Stomach:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Seldom <input type="checkbox"/> Fairly Often <input type="checkbox"/> Often <input type="checkbox"/>	21. ¹⁴⁷ <u>Insomnia:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Degree: 158</i> Seldom <input type="checkbox"/> Fairly Often <input type="checkbox"/> Often <input type="checkbox"/>
4. ¹⁴⁰ <u>Shortness of Breath:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	13. ¹⁴⁷ <u>Indigestion:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Degree: 154</i> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	22. <u>Fatigue Easily:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>
5. ¹⁴¹ <u>Pain or Discomfort in Chest:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	14. ¹⁴⁷ <u>Nausea or Vomiting:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Degree: 155</i> Seldom <input type="checkbox"/> Fairly Often <input type="checkbox"/> Often <input type="checkbox"/>	23. <u>Change in Weight:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> ¹⁴⁹ If "yes," did you: Lose weight <input type="checkbox"/> Gain weight <input type="checkbox"/> ¹⁵⁰ About how many pounds? _____ ¹⁵¹ Over what period of time? _____ ¹⁵² Did you try to bring about this change? Yes <input type="checkbox"/> No <input type="checkbox"/>
6. ¹⁴² <u>Difficulty in Swallowing:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	15. ¹⁴⁷ <u>Loss of Appetite:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Degree: 156</i> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	24. <u>Other Complaints:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Please specify: _____
7. ¹⁴³ <u>Constipation:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	16. ¹⁴⁶ <u>Blood in the Urine:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Degree: 157</i> Seldom <input type="checkbox"/> Fairly Often <input type="checkbox"/> Often <input type="checkbox"/>	
8. ¹⁴² <u>Diarrhea:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	17. ¹⁴⁶ <u>Difficulty in Urinating:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	
9. ¹⁴² <u>Recent Change in Bowel Habits:</u> <i>Degree: 153</i> Yes <input type="checkbox"/> No <input type="checkbox"/> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	18. ¹⁴⁶ <u>Too Frequent Urination:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	

25. Have you seen a doctor in the last year about any of the complaints listed above? Yes No

If "yes," which complaint(s)? _____

26. Have you had difficulty with constipation over a period of many years? Yes No

27. Have you had a cough over a period of many years? Yes No

28. How have you been feeling in the last month or two? Good Fair Poor

29. Are you sick at the present time? Yes No

160

161

MISCELLANEOUS:

226 1. What is your present occupation? _____

227 If retired, what was your previous occupation? _____

228 2. In your work, have you ever been exposed to gases, dusts, or fumes of any sort which might poss
fect your lungs? (Examples: painters are often exposed to fumes from solvents; some farmers are
to insecticide sprays; etc.) Yes No

If "yes," please describe: _____

3. In your work, have you ever been exposed to any chemicals, solvents, or oil products not mention
preceding question? Yes No

If "yes," please describe: _____

4. Have you ever worked with X-rays or radioactive material? Yes No

If "yes," please describe briefly: _____

229 5. Many people complain that their work or home situation puts them under pressure or nervous tensio
much pressure or nervous tension do you feel you are under?

None Slight Moderate Severe

230 6. Have you recently noticed any change in the size or color of a mole or wart? Yes No

231 7. Has a doctor ever removed a mole or wart from your skin? Yes No

232 8. Do you have a sore which will not heal? Yes No If "yes," where: _____

233 234 9. How many teeth have you lost? _____

235 10. Do you wear a full dental plate? Yes No A partial dental plate? Yes No

236 11. Are you bald or beginning to get bald? Yes No

If "yes," how bald? Slight Moderate Much

237 12. Are you circumcised?
Completely circumcised (foreskin absent) Some foreskin
Uncircumcised (full foreskin) Don't know

177 13. Frequency of sexual intercourse (times per month): _____

240 14. Religion: Protestant Catholic Jewish Other: _____

If Protestant, what denomination? _____
(We ask this because cancer of some sites is said to be rare in certain religious groups.
For example, cancer of the penis is rare in Jewish men.)

238 15. Did you ever live in a house with a person who had cancer? Yes No

If "yes," what was his or her relationship to you? _____

241 16. Do you have a medical check-up regularly every year? Yes No

242 17. Where were you born? _____

243 18. How many years have you lived in your present neighborhood? _____

244 19. Education: Grammar School Some High School High School Graduate Some College
College Graduate

245 20. Did the person whose name appears on the first page of this questionnaire fill out the questionnaire
himself? Yes No

REMARKS:

AMERICAN CANCER SOCIETY

CANCER PREVENTION STUDY

QUESTIONNAIRE FOR WOMEN

Division No.: 1-2	Unit No.: 3-5	Group No.: 6-8
Researcher No.: 9-11	Family No.: 12-13	Person No.: 14-15

Spouse in Study Code
352-353

1. Name: _____ 2. Date: 16
 3. Date of Birth: 17-18 5 yr. Group: 19 Month: _____ Year: _____ 4. Present Weight (Indoor clothing): _____ lbs.
 5. Height (Without shoes): 26-27 ft. _____ in. 6. Race: 28 White Negro Indian Other: _____
 7. Marital Status: 29 Single Married Widowed Divorced Separated
 8. If now married, did you have a previous marriage? Yes No

FAMILY HISTORY (IN RELATION TO CANCER): Please indicate for each of the following members of your family: whether living or dead; their present age or age at time of death; and whether or not they ever had cancer.

1. Your Parents and Grandparents:

- a) Father: 31 Status: 30 Alive Dead ; Age: _____ ; Cancer: Yes No ; Type of Cancer: 32-33
 b) Mother: 34 Alive Dead ; Age: _____ ; Cancer: Yes No ; Type of Cancer: 35-36
 c) Father's father: 37 Alive Dead ; Age (approximate): _____ ; Cancer: Yes No Don't know
 d) Father's mother: 34 Alive Dead ; Age (approximate): _____ ; Cancer: Yes No Don't know
 e) Mother's father: 41 Alive Dead ; Age (approximate): _____ ; Cancer: Yes No Don't know
 f) Mother's mother: 43 Alive Dead ; Age (approximate): _____ ; Cancer: Yes No Don't know

2. Your Brothers: (Please list all of them, living or dead). No. of brothers - 45

- 1) 46 Status: 46 a) Alive or Dead ; Age: 27 ; Cancer: Yes No ; Type of Cancer: 48-49
 2) 50 b) Alive or Dead ; Age: 31 ; Cancer: Yes No ; Type of Cancer: 52-53
 3) 54 c) Alive or Dead ; Age: 35 ; Cancer: Yes No ; Type of Cancer: 56-59
 4) 56 d) Alive or Dead ; Age: 34 ; Cancer: Yes No ; Type of Cancer: 60-61
 5) 62 e) Alive or Dead ; Age: 63 ; Cancer: Yes No ; Type of Cancer: 64-65

3. Your Sisters: (Please list all of them, living or dead). No. of sisters - 74

- 1) 75 Status: 75 a) Alive or Dead ; Age: 71 ; Cancer: Yes No ; Type of Cancer: 72-73
 2) 79 b) Alive or Dead ; Age: 80 ; Cancer: Yes No ; Type of Cancer: 77-78
 3) 83 c) Alive or Dead ; Age: 84 ; Cancer: Yes No ; Type of Cancer: 81-82
 4) 87 d) Alive or Dead ; Age: 88 ; Cancer: Yes No ; Type of Cancer: 84-86
 5) 91 e) Alive or Dead ; Age: 92 ; Cancer: Yes No ; Type of Cancer: 87-90
 6) 95 f) Alive or Dead ; Age: 96 ; Cancer: Yes No ; Type of Cancer: 93-94

4. Do you (or did you) have a twin sister? Yes No ; If "yes," indicate above which sister.

5. When you were born: How old was your mother? 99 How old was your father? 100-101

HISTORY OF DISEASES:

1. Have you ever had cancer? Yes No
 If "yes," a) What type of cancer? 102-103 b) Date of first treatment: 104-105
2. Please make a check mark after the name of each of the following diseases you have ever had.
- | | | | | | |
|----------------------------------------|---------------------------------------|----------------------------------------------|------------------------------------------|---------------------------------------------|--------------------------------------|
| Pneumonia <input type="checkbox"/> | Tuberculosis <input type="checkbox"/> | Bronchitis <input type="checkbox"/> | Influenza <input type="checkbox"/> | Laryngitis <input type="checkbox"/> | Tonsillitis <input type="checkbox"/> |
| Asthma <input type="checkbox"/> | Hay fever <input type="checkbox"/> | Dysentery <input type="checkbox"/> | Stomach Ulcer <input type="checkbox"/> | Duodenal Ulcer <input type="checkbox"/> | Diabetes <input type="checkbox"/> |
| Heart Disease <input type="checkbox"/> | Stroke <input type="checkbox"/> | High Blood Pressure <input type="checkbox"/> | Rheumatic Fever <input type="checkbox"/> | Cirrhosis of Liver <input type="checkbox"/> | |
| Gallstones <input type="checkbox"/> | Arthritis <input type="checkbox"/> | Poliomyelitis <input type="checkbox"/> | Goiter <input type="checkbox"/> | | |
- Any serious disease not listed above: (please specify): _____
3. How often have you had colds (or gripp) in the last year? 1-6

4. Have you ever had a surgical operation? Yes No Summary - 129

If "yes," please specify type of operation(s): 130-135

5. Have you ever had an X-ray or fluoroscopic examination of your stomach or abdomen? Yes No ¹³⁶

6. Have you ever been treated with radium, X-rays, or radioactive isotopes? Yes No ¹³⁷

If "yes," what part of your body? _____

What disease were you treated for? _____

PRESENT PHYSICAL COMPLAINTS: Please check "yes" or "no" after each complaint listed. If you check "yes," please indicate the severity of the condition.

1. ¹³⁸ <u>A Cough:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	10. ¹⁴⁴ <u>Blood in the Stool:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Seldom <input type="checkbox"/> Fairly Often <input type="checkbox"/> Often <input type="checkbox"/>	19. ¹⁴⁷ <u>Unusual Bleeding from Vagina:</u> Yes <input type="checkbox"/> No <input type="checkbox"/>
2. ¹³⁹ <u>Sore Throat:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	11. ¹⁴⁴ <u>Pain or Discomfort in Lower Abdomen:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Seldom <input type="checkbox"/> Fairly Often <input type="checkbox"/> Often <input type="checkbox"/>	20. ¹⁴⁷ <u>Unusual Discharge from Vagina:</u> Yes <input type="checkbox"/> No <input type="checkbox"/>
3. ¹³⁹ <u>Hoarseness:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	12. ¹⁴⁴ <u>Pain in Stomach:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Seldom <input type="checkbox"/> Fairly Often <input type="checkbox"/> Often <input type="checkbox"/>	21. ¹⁴⁷ <u>Headaches:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Seldom <input type="checkbox"/> Fairly Often <input type="checkbox"/> Often <input type="checkbox"/>
4. ¹⁴² <u>Shortness of Breath:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	13. ¹⁴⁵ <u>Indigestion:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> ^{Degree: 154} Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	22. ¹⁴⁸ <u>Dizziness:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Seldom <input type="checkbox"/> Fairly Often <input type="checkbox"/> Often <input type="checkbox"/>
5. ¹⁴¹ <u>Pain or Discomfort in Chest:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	14. ¹⁴⁵ <u>Nausea or Vomiting:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> ^{Degree: 155} Seldom <input type="checkbox"/> Fairly Often <input type="checkbox"/> Often <input type="checkbox"/>	23. ¹⁴⁵ <u>Insomnia:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> ^{Degree: 158} Seldom <input type="checkbox"/> Fairly Often <input type="checkbox"/> Often <input type="checkbox"/>
6. ¹⁴² <u>Difficulty in Swallowing:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	15. ¹⁴⁵ <u>Loss of Appetite:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> ^{Degree: 156} Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	24. ¹⁴⁵ <u>Fatigue Easily:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> ^{Degree: 159} Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>
7. ¹⁴³ <u>Constipation:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	16. ¹⁴⁶ <u>Blood in the Urine:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> ^{Degree: 157} Seldom <input type="checkbox"/> Fairly Often <input type="checkbox"/> Often <input type="checkbox"/>	25. <u>Change in Weight:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> ¹⁴⁹ If "yes," did you: Lose weight <input type="checkbox"/> Gain weight <input type="checkbox"/> ¹⁵⁰ About how many pounds? _____ ¹⁵¹ Over what period of time? _____ ¹⁵² Did you try to bring about this change? Yes <input type="checkbox"/> No <input type="checkbox"/>
8. ¹⁴² <u>Diarrhea:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	17. ¹⁴⁶ <u>Lump or Thickening in Breast:</u> Yes <input type="checkbox"/> No <input type="checkbox"/>	26. <u>Other Complaints:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> Please specify: _____
9. ¹⁴² <u>Recent Change in Bowel Habits:</u> Yes <input type="checkbox"/> No <input type="checkbox"/> ^{Degree: 153} Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Severe <input type="checkbox"/>	18. ¹⁴⁶ <u>Unusual Discharge from Breast:</u> Yes <input type="checkbox"/> No <input type="checkbox"/>	

27. Have you seen a doctor in the last year about any of the complaints listed above? Yes No

If "yes," which complaint(s)? _____

28. Have you had difficulty with constipation over a period of many years? Yes No ¹¹⁶⁰

29. Have you had a cough over a period of many years? Yes No

30. How have you been feeling in the last month or two? Good Fair Poor } ¹⁶¹

31. Are you sick at the present time? Yes No

If "yes," what disease? _____

QUESTIONS RELATING TO BREAST AND FEMALE GENITAL ORGANS:

- 162 } 1. Have you ever had an injury to your breast? Yes No . If yes, which breast? _____
- 163 } 2. Many doctors recommend that women examine their breasts monthly. Do you do so? Yes No
- 164 } 3. How old were you when menstruation began? _____
- 164 } 4. Menstruation when you were about 20 years old:
 a) Regular or Irregular
 165 - b) Usual number of days of flow: _____
 166 - c) How painful? None Slight Moderate Severe
- 167 } 5. Menstruation in recent months:
 a) Regular Irregular Pregnant Past Menopause
 168 - b) Usual number of days of flow: _____
 169 - c) How painful? None Slight Moderate Severe
- 170 } 6. If past menopause: → a) Age when menopause began: _____
 b) Did you have excessive bleeding during menopause? Yes No
- 171 - Pregnancy Pattern
 172 } Number of children born alive: _____ Number stillborn (carried at least 6 months): _____
 Number miscarriages (carried less than 6 months): _____
- 173 } 8. Your age at time of first pregnancy: _____
- 174 } 9. Breast feeding of children. a) Number breast fed for over 2 months: _____
 b) Number breast fed for from 2 weeks to 2 months: _____
 c) Number breast fed for less than 2 weeks: _____
 d) Number never breast fed: _____
- 175 } 10. Did you ever take medicine to prevent the flow of milk? Yes No
- 176 } 11. If you did not breast feed one or more of your children, why not?
 Lack of milk Painful nipple Breast Abscess Preferred Not To Other: _____
- 177 } 12. If you are now married: Frequency of Intercourse (times per month): _____
- 178 } 13. Did you ever have an X-ray or fluoroscopic examination of your abdomen when pregnant? Yes No

HABITS: Blank for females 181-182, 189

- 181 } 1. How much exercise do you get (work or play): None Slight Moderate Heavy
- 182 } 2. How many hours of sleep do you usually get a night? _____
3. Do you now smoke? Yes No
- 183 } If "yes," a) How many cigarettes do you usually smoke a day? _____
 184 } b) About how much do you inhale when smoking cigarettes?
 Do not inhale Inhale slightly Inhale moderately Inhale deeply
 185 } c) What type do you smoke? Filter-tip Without filter-tip
 d) What brand do you usually smoke? _____
 186 } e) How old were you when you started smoking cigarettes? _____
4. If you do not smoke cigarettes now, did you ever smoke cigarettes regularly? Yes No
- If "yes," 187 } a) How long has it been since you last smoked cigarettes regularly? _____
 188 } b) How many cigarettes did you usually smoke per day? _____
 c) Why did you stop smoking cigarettes? _____
5. How many days a week do you eat each of the following food:
 Fish 190 ; Meat or poultry 191 ; Eggs 192 ; Cheese 193 ; Butter or oleomargarine 194 ;
 Bread, rolls, or biscuits 195 ; Pancakes 196 ; Cereal 197 ; Spaghetti or macaroni 198 ;
 Potatoes 199 ; Rice 200 ; Cooked vegetables 201 ; Green salads 202 ; Fruits or fruit juices 203 ;
 Sweet desserts 204 ; Candy 205 .

2066. When eating meat, do you avoid eating the fat? Yes No

2077. How many days a week do you eat each of the following fried foods:

Fried eggs _____; Fried bacon, fried sausage, or fried ham _____; Fried potatoes _____;

Fried chicken or fried fish _____; Other fried food _____.

2088. Do you save grease, lard, oil, etc. and use it repeatedly for frying? Yes No

2099. Do you often add salt to your food? Yes No ; Pepper? Yes No ;

210 Catsup, mustard, or spices? Yes No ; Mayonnaise or salad oil? Yes No

2110. Do you often eat: Ham? Yes No ; Pork Chops? Yes No ; Other pork? Yes

212 Frankfurters? Yes No ; Smoked or salt fish? Yes No

11. How many cups, glasses, or "drinks" of the following beverages do you usually take a day?

a) Milk 213; b) Coffee 214; c) Tea 215; d) Soft drinks 216;

e) Beer 217; f) Wine 218; g) Whiskey, gin, etc. 219.

22012. When drinking coffee, tea, or soup, do you take it: Very hot Moderately hot Lukewarm

22113. Do you have to avoid certain foods or drinks because they give you indigestion? Yes No

If "yes," what foods or drinks? _____

14. How often do you use the following types of medicine?

223 Aspirin, Bufferin... Never Seldom Often ;

224 Vitamin pills... Never Seldom Often ;

225 Sleeping pills... Never Seldom Often ;

222 } Tranquilizers Never Seldom Often

222 } Laxatives Never Seldom Often

222 } Anti-acid medicine. Never Seldom Often

24115. Do you have a medical check-up regularly every year? Yes No

MISCELLANEOUS:

2261. What is your present occupation: _____

227 If retired, what was your previous occupation? _____

2. Many people complain that their work or home situation puts them under pressure or nervous tension.

229 How much pressure or nervous tension do you feel you are under?

None Slight Moderate Severe

2303. Have you recently noticed any change in the size or color of a mole or wart? Yes No

2324. Do you have a sore which will not heal? Yes No . If "yes," where: _____

233 235. How many teeth have you lost? _____

2356. Do you wear a full dental plate? Yes No . A partial dental plate? Yes No

2387. Did you ever live in a house with a person who had cancer? Yes No

If "yes," what was his or her relationship to you? _____

2398. Has a child of yours had cancer (including leukemia)? Yes No . If "yes," what type: _____

2409. Religion: Protestant Catholic Jewish Other: _____

If Protestant, what denomination? _____

(We ask this because cancer of some sites is said to be rare in certain religious groups. For example, cancer of the cervix is rare in Jewish women.)

24210. Where were you born? _____

24711. Education: Grammar school Some high school High school graduate Some college
College graduate

24512. Did the person whose name appears on the first page of this questionnaire fill out this questionnaire herself? Yes No

REMARKS:

SECOND QUESTIONNAIRE CARD

FRONT

	Family Number	Person Number	NAME: <u>Assigned + Reassigned 2nd Q card.</u>	Div. No	Unit No	Group No	Res. No
TARGETED POPULATION AND SPECIAL CANCER SOCIETY			<u>259 - Hosp. Rel. 2/10/60</u>				
			<u>273</u>				
			<u>Assigned + Reassigned 2nd Q card.</u>				
			<u>259 - Hosp. Rel. 2/10/60</u>				
		1. Have you been hospitalized at any time since October 1, 1959? Yes <input type="checkbox"/> No <input type="checkbox"/>					
		If "yes": a) Disease(s): <u>1st Field 249-250</u> <u>2nd Field 251-252</u> <u>3rd Field 253-254</u>					
		b) Date(s):					
		2. Have you had a surgical operation since October 1, 1959? Yes <input type="checkbox"/> No <input type="checkbox"/>					
		If "yes": a) Type of operation(s):					
		b) Date(s):					
		3. Have you ever had cancer? Yes <input type="checkbox"/> No <input type="checkbox"/>		<u>Site</u>	<u>Accuracy of diagnosis</u>		
		If "yes": a) What type of cancer?		<u>255-256</u>	<u>258</u>		
		b) Date of first treatment:		<u>257</u>			
		4. Have you had any other serious diseases since October 1, 1959? Yes <input type="checkbox"/> No <input type="checkbox"/>					
		If "yes": What diseases?					

(OVER)

BACK

Movement - State 274-275

1. Home address: City Movement - Area + Place 276-277 P.O. ZONE NO. _____ State: _____

2. Were you living here in 1959? Yes No 260

3. Location of your home: In country Outskirts of town Center of town 261

4. Is your home in an area with heavy air pollution from factories, power plants, refineries, etc.? Yes No 262

5. Do you work in such an area (i.e., heavy air pollution)? Yes No 263

6. How many hours a week are you in automobiles, buses, or trucks? _____ hours. 264-265

7. Do you now smoke cigarettes? Yes No

If yes: a) How many cigarettes do you usually smoke a day? 266

b) What brand do you usually smoke? 267-268

8. Have you ever been vaccinated against: 269

Tetanus? Yes No 270 Smallpox? Yes No 271

Polio? Yes No 272 Diphtheria? Yes No 273

(OVER)

THIRD QUESTIONNAIRE CARD

FRONT

Div. No.	Unit No.	Group F.D.	Res. No.	Fam. No.	Pers. No.	NAME
						289 <i>Disease on Front</i>
AMERICAN CANCER SOCIETY	283 - Hospitalization					
	1. Have you been hospitalized at any time since October 1, 1961? Yes <input type="checkbox"/> No <input type="checkbox"/>					
	If "yes": a) Disease(s): <u>1st Field</u> <u>2nd Field</u> <u>3rd Field</u>					
	b) Date(s): <u>278-279</u> <u>280-281</u> c) Name of hospital: <u>282-283</u>					
2. Have you had a surgical operation since October 1, 1961? Yes <input type="checkbox"/> No <input type="checkbox"/>						
If "yes": a) Type of operation(s):						
b) Date(s):						
3. Have you developed <u>cancer</u> since October 1, 1961? Yes <input type="checkbox"/> No <input type="checkbox"/>						
If "yes": a) What type of cancer? <u>Site</u> <u>Accuracy of Diagnosis</u>						
b) Date of first treatment: <u>284-285</u> <u>287</u>						
4. Have you had any other serious diseases since October 1, 1961? Yes <input type="checkbox"/> No <input type="checkbox"/>						
If "yes": What diseases?						

JTC 3056X

(OVER)

BACK

Movement - State - 299-300

1. Home address: City Movement - Areas Place P. O. Zone No. 301-302 State: _____

2. Were you living at the above address in 1961? Yes No

if you have moved since 1961:

291 a) Location of your present home: In country Outskirts of town Center of town

292 b) Is your present home in an area with heavy air pollution from factories, power plants, refineries, etc.? Yes No

3. Did you ²⁹³ live on a farm early in life? Yes No

If "yes": Up to what age did you live on a farm? 294-295

4. Do you now smoke cigarettes? Yes No

If "yes": a) How many cigarettes do you usually smoke a day? 296

b) What brand do you usually smoke? 297-298

JTC 3056X

(OVER)

FOURTH QUESTIONNAIRE CARD

FRONT

DIV NO.	UNIT NO.	GROUP NO.	RES. NO.	FAM. NO.	PEER NO.	NAME: <u>319 Disease on Front</u>
---------	----------	-----------	----------	----------	----------	-----------------------------------

1. Date this questionnaire is answered: Month 303 Day _____ Year 1963

Are you sick at the present time? Yes No

2. Have you been hospitalized at any time since October 1, 1963? Yes No
318 - Hospitalization

If "yes": a) Disease(s): 1st Field 308-309 2nd Field 310-311 3rd Field 312-313
 b) Date(s): _____ c) Name of hospital: _____

3. Have you had a surgical operation since October 1, 1963? Yes No

If "yes": a) Type of operation(s): _____
 b) Date(s): _____

4. Have you developed cancer since October 1, 1963? Yes No

If "yes": a) What type of cancer? Site 314-315 Accuracy of Diagnosis 317
 b) Date of first treatment? 316

AMERICAN CANCER SOCIETY

DM C70034-0

(OVER)

BACK

1. Since October 1, 1963, have you had any serious diseases not mentioned on the front of this card? Yes No

If "yes": What diseases? _____

2. Home address: City _____ P.O. Zone No. _____ State: _____

304

3. Were you living at the above address in 1963? Yes No

4. Do you now smoke cigarettes? Yes No

If "yes": a) How many cigarettes do you usually smoke a day? 305
 b) What brand do you usually smoke? 306-307

DM C70034-0

(OVER)

FIFTH QUESTIONNAIRE (1972)

AMERICAN CANCER SOCIETY
Cancer Prevention Study
Questionnaire

If above address is incorrect, please write correct address below:

Address: 415

Zip Code:

1. DATE: Month: 376-377 Day: 19 378-379

2. Date of Birth: Month: 380-381 Day: Year: 382-383 Sex: Male Female

3. Have you ever had cancer? YES NO 385

If "yes": a) What type of cancer? 386-387

b) Date of first treatment. 388-389

4. Have you ever had: Heart Disease? YES NO 390 High blood pressure? YES NO 391

Diabetes? YES NO 392 Stroke? YES NO 393 Cirrhosis of Liver? YES NO 394

Gastric or Duodenal Ulcer? YES NO 395 (Women) Hysterectomy? YES NO 396

5. Have you been hospitalized at any time since Oct. 1, 1965? YES NO 397

If "yes": a) Disease(s)

b) Date(s)

6. Are you sick now? YES NO 398

7. Do you now smoke cigarettes? YES NO 399

If "yes": a) How many cigarettes a day? 400-401

b) What brand do you usually smoke?

c) Filtertip? YES NO 401 d) Menthol? YES NO 405

8. Do you now smoke cigars daily? YES NO 406

Pipes daily? YES NO 407

9. Have you had a medical examination in the last 12 months? YES NO 408

10. Have you ever had a proctoscopic examination (an instrument examination of rectum)? YES NO 409

If so, in last year? YES NO 410

11. WOMEN:

a) Have you ever had a "Pap smear"? YES NO 411 If so, in last 12 months? YES NO 412

b) Do you examine your breasts regularly? YES NO 413

c) Have you ever had an x-ray of your breasts (mammogram)? YES NO 414

American Cancer Society--University of California
CANCER PREVENTION STUDY
1999 Follow-up Questionnaire

Full Name: _____

Address: _____

Telephone: () _____ - _____ Sex: Male Female

Date of Birth: _____ - _____ - _____ Height: _____ Ft _____ In Weight: _____ Lbs
 Month Day Year

Where were you born (state or country)? _____

What is or was your primary occupation? _____

Education: _____ Grammar school _____ Some high school _____ High school graduate
 _____ Some college _____ College graduate _____ Graduate school

Marital status: _____ Never married _____ Married _____ Widowed _____ Divorced _____ Separated

Number of times married: _____ Age when first married: _____

How many years have you lived in your present neighborhood? _____

Have you smoked at least 100 cigarettes in your life? Yes (see next question) No (go to cigar question)

Do you now smoke cigarettes? Yes No

If yes:

If no: How old were you when you quit? _____

How many cigarettes a day? _____

How many cigarettes a day? _____

How many years have you smoked? _____

How many years did you smoke? _____

What brand do you usually smoke? _____

What brand did you usually smoke? _____

How much do you inhale?
 _____ none _____ slightly _____ moderately _____ deeply

How much did you inhale?
 _____ none _____ slightly _____ moderately _____ deeply

Do you now smoke cigars daily? Yes No

Did you ever smoke cigars regularly? Yes No

Do you now smoke pipes daily? Yes No

Did you ever smoke pipes regularly? Yes No

Do you chew tobacco or use snuff? Never Occasionally Regularly

Have you ever lived with a smoker? Yes No

If yes, who? _____ Spouse _____ Relative _____ Other

Did they regularly smoke in your presence? Yes No

What type of tobacco? _____ Cigarettes _____ Cigars _____ Pipes

How many years were you exposed to their smoke? _____

Religion: ___ Protestant ___ Catholic ___ Jewish ___ Mormon ___ Other ___ None

How many times a month do you go to religious services? _____

How much exercise do you get (work or play): ___ None ___ Slight ___ Moderate ___ Heavy

How many hours of sleep do you usually get a night? _____

How many days a week do you eat each of the following foods?

Meat ___ Poultry ___ Fish ___ Eggs ___ Cheese ___ Butter ___ Margarine ___

Green salads ___ Raw vegetables ___ Cabbage/broccoli ___ Potatoes ___ Carrots ___

Spaghetti/macaroni ___ Tomatoes ___ Citrus fruits or juices ___ Desserts ___ Candy ___

How many cups, glasses, or "drinks" of the following beverages do you usually take a day?

Milk ___ Coffee ___ Tea ___ Soft drinks ___ Beer ___ Wine ___ Hard liquor ___

How often do you use the following? Never Seldom Often If daily, amount Years of use

Vitamin C	_____	_____	_____	_____ mg	_____
Vitamin E	_____	_____	_____	_____ IU	_____
Vitamin A	_____	_____	_____	_____ IU	_____
Multi-vitamins	_____	_____	_____	_____	_____
Aspirin, Bufferin, Anacin	_____	_____	_____		
Sleeping pills	_____	_____	_____		

In your work or daily life, are (were) you regularly exposed to any of the following?

If "yes," estimate the number of years exposed.

	No	Yes			Years
		Light	Moderate	Heavy	
Asbestos	_____	_____	_____	_____	_____
Chemicals/solvents/oils	_____	_____	_____	_____	_____
Cigarette smoke from others	_____	_____	_____	_____	_____
Gases/dusts/fumes	_____	_____	_____	_____	_____
X-rays/radioactive materials	_____	_____	_____	_____	_____

Do you have a medical check-up regularly every year? ___ Yes ___ No

Your current overall health status? ___ excellent ___ good ___ fair ___ poor

Are you sick at the present time? ___ Yes ___ No

If yes, what disease or condition? _____

Have you ever had cancer? ___ Yes ___ No If yes, what type? _____ Year? _____

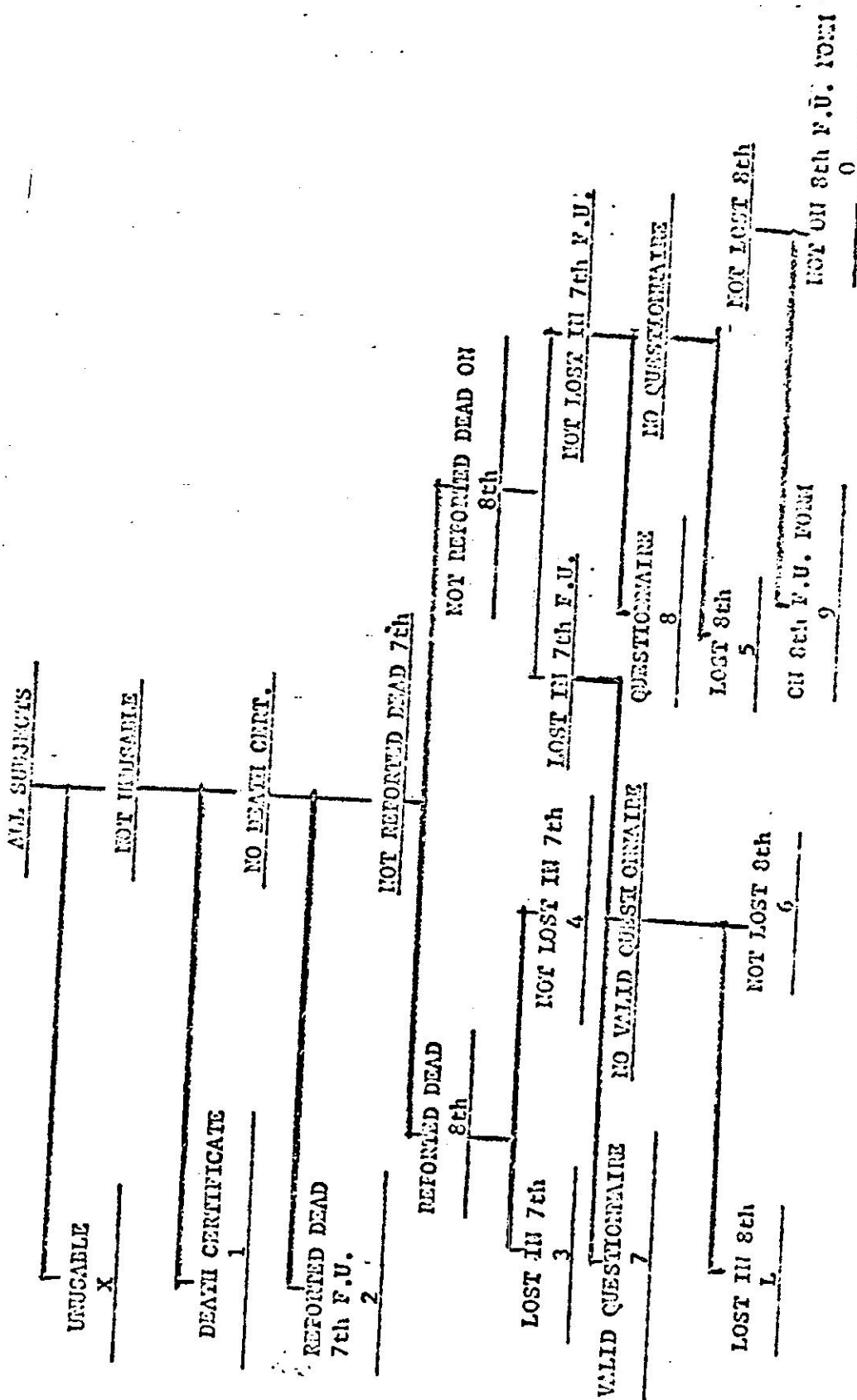
Are you willing to complete a future lifestyle questionnaire? ___ Yes ___ No

Would you like information on how you can help this study further? ___ Yes ___ No

Signed: _____ Date: _____

Results of 7th and 8th F.U.
 (As used for January 1975
 Updating of tape)

For Appendix



HAND WRITTEN DEATH CARD

CAUSE OF DEATH CODE (Columns 361-362, 363-364, and 365-)

<u>CODE</u>	<u>INT'L LIST NO.</u>	<u>TITLE</u>
<u>00-06 Heart</u>		
00	420.0	A.S.H.D.
01	420.1 420.2	Coronary & Myocardial Infarction Angina Pectoris
02	400-402 410-416	Rheumatic Fever Chronic Rheumatic Heart
03	440-443	Hypertensive Heart
*04	422	Myocardial Degeneration
*05	421 430-433 Part of 434	Other Heart (except cor pulmonale)
06	434.4 (part only)	Cor Pulmonale
<u>07-09 Cerebral Vascular Lesions</u>		
(Note: Code only one of these following international list rules of priority).		
07	330, 331	Cerebral Hemorrhage (vascular accident)
08	332	Cerebral Thrombosis and Embolism
09	333, 334	Other Vascular Lesions of Central Nervous System
<u>10-14 Miscellaneous Circulatory</u>		
(Note: Two or more of these may be coded. If there is not space to code all, then use priority as listed)		
10	453	Peripheral Vascular Disease
11	451	Aortic Aneurysm (non-syphilitic)
12	452	Other Aneurysm (non-syphilitic; except of heart and aorta)
13	463-466	Phlebitis, Pulmonary Embolism, Other Venous Embolism
14	454-456 460-462 467-468	Other Circulatory (Arterial embolism, gangrene, other artery disease; varicose veins, hemorrhoids; other diseases of circulatory system)

Code only one of these, 00 has priority over 01

Do not code if 00-03. Do not code both 04 and 05. (04 priority over 05)

Cause of Death Code (continued)

CODE	INT'L LIST NO.	TITLE
<u>15-16 Hypertension and Arteriosclerosis</u>		
(Note: do not code either of these if any other cardiovascular disease is coded 00-14)		
*15	444-447	Hypertension (without mention of heart)
*16	450	General Arteriosclerosis
<u>20-39 Miscellaneous Diseases, Suicide, and Accidents</u>		
(Note: Two or more of these may be coded, if insufficient space, use the priority)		
20	210-239	Benign Tumors
21	541	Ulcer, duodenal
22	540, 542	Ulcer, Stomach or Gastrojejunal
23	022, 023	Aneurysm of aorta and other Cardiovascular Syphillis
24	590-594 600-603	Nephritis, Nephrosis, and other Kidney Disease
25	581	Cirrhosis of Liver
26	570-578	Other Intestinal and Peritoneum
27	584-586	Cholelithiasis and Cholecystitis
28	260	Diabetes
29	610-614	Benign Prostatic Diseases
30	001, 002	Pulmonary Tuberculosis
31	480, 481	<u>Respiratory Influenza</u> <u>Influenza, NOS</u>

(490-493)

Pneumonia as an Independent Disease

Rule I - (Pneumonia as the Underlying Cause of Death). If there is no other cause given in Part I of death certificate, code pneumonia here regardless of duration and regardless of qualifying terms, include "active or acute congestion of lung". If there is some other cause of death follow the general rule that pneumonia is not usually coded as the underlying cause unless it weak or unless doctor clearly specifies pneumonia as underlying cause of death.

Cause of Death Code (continued)

<u>CODE</u>	<u>INT'L LIST NO.</u>	<u>TITLE</u>
31 (cont'd)	(490-493)	<u>Pneumonia as an Independent Disease (cont'd)</u> <u>Rule II</u> - (Pneumonia as a Secondary Cause of Death). Code pneumonia here as a secondary cause of death only if duration is 1+ weeks; do not code here as a secondary cause of death if specified as "terminal", "hypostatic" etc. regardless of duration. Note applies to both rules I and II. If pneumonia or influenza not <u>also</u>
*32	32 (490-493)	<u>Pneumonia Presumably Resulting From Other Disease</u> <u>Note:</u> This code is <u>never</u> used for underlying cause of death. <u>Rule:</u> If some other disease is underlying cause of death, use this code for pneumonia <u>less than 1 week</u> , unknown, or unspecified duration, or "active or acute congestion of lung" less than 1 week; or, regardless of duration, "terminal pneumonia" and "secondary pneumonia".
33	33 (525)	Pulmonary fibrosis; Fibrosis of Lungs
	526	Bronchiectasis
	527.0	Atelectasis; collapse of lungs, pulmonary collapse.
30	30 527.1	Emphysema (with or without bronchitis)
		<u>Note:</u> 33 and 30 are always coded.
34	34 500-502	Bronchitis
		<u>Note:</u> If code 30 is used, do not also code 34
35	35 241	Asthma
36	36 520, 521, 523, 524	Other Pulmonary Diseases (except Secondary Terminal Conditions, see below).
*37	37 522, (525), 527.2	<u>Other Pulmonary Diseases Secondary to Other Diseases</u> <u>Note:</u> Never use this code for underlying cause of death unless it is the <u>only</u> thing mentioned on a death certificate.
38	38 E970-E979	Suicide

Cause of Death Code (continued)

<u>CODE</u>	<u>INT'L LIST NO.</u>	<u>TITLE</u>
39	39 E800-E965 E980-F999	Accidents and Violence
XI	XI -- --	Other specified diseases (i.e. international list numbers not elsewhere listed in this code).
XX	XX 780-795	Ill defined. <u>Note:</u> Use XX as underlying cause only if nothing else is mentioned. Never use XX as secondary cause of death
40-99	140-205 .	<u>See Cancer Code</u>

CANCER CODE

This code is used for the following:

Cancer in Parents and Siblings (Columns 32-33, 35-36 and 48-49, 52-53, 56-57, 60-61, 64-65, 68-69, 72-73, 77-78, 81-82, 85-86, 89-90, 93-94, 97-98)

Cancer on Original Questionnaire (Columns 102-103)

Cancer on Supplementary Questionnaire Cards (Columns 255-256, 284-285, and 314-315)

Cancer as Cause of Death (Columns 361-362, 363-364, and 365-366)

<u>Code</u>	<u>Title</u>	<u>Code</u>	<u>Title</u>	<u>Code</u>	<u>Title</u>
40	Lip	58	Peritoneum	80	Kidney
41	Tongue	59	Unspecified Digestive Organs	81	Bladder and Other Urinary Organs
42	Salivary Gland	60	Nose, Nasal Cavities, etc.	82	Other Forms of Lymphoma
43	Floor of Mouth	61	Larynx	83	Multiple Myeloma
44	Other Parts of Mouth, Mouth Unspecified	62	Bronchus, and Lung	84	Leukemia
45	Oral Mesopharynx	63	Trachea and Pleura	85	Mycosis Fungoides
46	Nasopharynx	64	Mediastinum	86	Hodgkins Disease
47	Hypopharynx	70	Breast	87	Lymphosarcoma and Reticulosarcoma
48	Pharynx, Unspecified	71	Cervix Uteri	90	Melanoma of Skin
50	Esophagus	72	Corpus Uteri	91	Skin
51	Stomach	73	Chorionepithelioma	92	Eye
52	Small Intestine, including Duodenum	74	Uterus, Unspecified	93	Brain
53	Large Intestine	75	Ovary, Fallopian Tube, etc.	94	Thyroid Gland
54	Rectum	76	Other and Unspecified Female Genital Organs	95	Other Endocrine Glands
55**	Biliary Passages and Liver	77	Prostate	96	Bone
57	Pancreas	78	Testis	97	Connective Tissue
		79	Other and Unspecified Male Genital Organs	98*	Precancerous
				99	Other and Unspecified

* - Used only for question on cancer on Original Questionnaire (Columns 102-103).
 ** - For Cause of Death Only: 55 - Liver; 5E - Gall Bladder, 5H - Biliary passages
 and ducts, Ampulla of Vater

SUPPLEMENTARY DISEASE CODE

This code is used for the following:

- Second Questionnaire Card (Columns 249-250, 251-252 and 253-254)
- Third Questionnaire Card (Columns 278-279, 280-281 and 282-283)
- Fourth Questionnaire Card (Columns 308-309, 310-311 and 312-313)

Pregnancy and Complication of Pregnancy

- 01 - Childbirth, apparently normal
- 02 - Miscarriage, Abortion, Stillbirth
- 03 - Caesarian
- 04 - Other Abnormal pregnancy, Tubular pregnancy
- **05 - Pregnant now

Note: Disregard "tubes tied".

Female Organs

- 11 - Hysterectomy
- 12 - Hysterectomy and Breast
- 13 - Breast (without D. & C.)
- 14 - Breast and D. & C.
- 15 - D. & C. only
- 16 - D. & C. and Other Female
- 17 - Other Female Genital

Note: Code only one field between 11 and 16.

D. & C. combined with "polyp" or "Bartholin gland" goes to D. & C. only.

Cardiovascular

- 21 - Heart
- 22 - Stroke, cerebral hemorrhage, cerebral thrombosis
- 23 - Phlebitis, varicose veins, Buerger's Disease
- 24 - Other embolism, clot, thrombosis and other peripheral vascular diseases
- **25 - High blood pressure, hypertension
- **26 - Other circulatory, "cardiovascular", hardening of arteries, arteriosclerosis, rheumatic fever without heart, etc.

Gastro-Intestinal

- 31 - Ulcer (Peptic, gastric, duodenal and intestinal) also Ulcer NOS
- 32 - Gall bladder
- 33 - Rectal disorders (except hemorrhoids) or Anal disorders
- 34 - Liver
- *35 - Hemorrhoids
- *36 - Hernia
- *37 - Appendicitis
- **38 - Other Gastro-Intestinal (i.e., colitis, diverticulosis, stomach trouble, etc)

Supplementary Disease Code
(Continued)

Kidney, Urinary Bladder, Prostate and Other Male Genital

- 41 - Bladder
- 42 - Prostate
- 43 - Kidney
- 44 - Other Urinary (Male or Female) and Other Male Genital

Lung, Larynx, Esophagus

- 52 - Larynx
- 53 - Esophagus
- 54 - Tuberculosis
- 55 - Pneumonia, pleurisy, bronchitis
Influenza (but not intestinal flu)
- 56 - Asthma
- 57 - Other lung conditions

Tumors and Growth

- 61 - "Tumor", benign tumor or removal of mole, polyp, papilloma, or "growth"
Code here only if it cannot be coded to a site.

Miscellaneous Specified Diseases

- *71 - Diabetes
- *72 - Goiter, thyroid
- *73 - Arthritis
- *74 - Eye disorder (not tumor)
- *75 - Ear disorder and mastoid (not tumor)
- *76 - Dental disorder (not tumor)
- *77 - Sinus trouble
- **78 - Hospitalized for: nervous tension, mental disorder, etc.

Other Non-Specified Diseases or Check-Up

Code 81-99 only if no other codes are used.

- 81 - All other diseases
- 82 - Some questions checked "yes" but no details given
- 83 - Check-up NOS or Observation NOS
- 84 - Sick at present checked "yes" but no details given

Accidents

- 98 - Accident but no disease on questionnaire cards. Includes fracture not specified as pathologic, also slipped disc

Cancer Only

- 99 - Nothing recorded except cancer

Note: Numbers that are asterisked are not to be used if there are 3 other conditions to be coded. Conditions with one asterisk take priority over those with 2 asterisks.

BRAND OF CIGARETTE CODE FOR 1972 QUESTIONNAIRE
(See col. 402-403)

01	Belair	15	Parliament
02	Benson & Hedges	16	Raleigh
03	Camel	17	Salem
04	Chesterfield	18	Silva Thins
05	Doral	19	Tareyton
06	Kent	20	True
07	Kool	21	Vantage
08	L & M	22	Viceroy
09	Lark	23	Virginia Slims
10	Lucky Strike	24	Winston
11	Marlboro	97	All other brands
12	Newport	98	More than one brand
13	Old Gold	99	Not stated or unknown
14	Pall Mall		

Death Certificate Residency Data

ile

Female

422

Address Match

- 0 - Same place - Same code.
- 1 - Different place - Same code.
- 2 - Same place - Different code. (e.g. one implies rural other does not)
- 3 - Different place - Different code.
- 4 - Adequate death certificate information; no definite "list of families" information.
- X - No death certificate or no readable address on death certificate. If 2, 3 or 4, code columns 423-426

55-57

423-424

423-424

Residence at Time of Death

State (See state code)

City (See area & place code - columns 246, 247)

425-426

425-426

State of Death on Death Certificate
(See state code)

429

429

Date of Birth

Month

- 1 - January
- 2 - February
- 3 - March
- 4 - April
- 5 - May
- 6 - June
- 7 - July
- 8 - August
- 9 - September
- 0 - October
- X - November
- Y - December
- Blank - Unknown

430-431

430-431

Day - Code directly (two digits)
XX - Unknown

432-433

432-433

Year - Code last two digits directly.
XX - Unknown

434

434

Marital Status

- 1 - Single
- 2 - Married
- 3 - Widowed
- 4 - Divorced
- 5 - Separated
- X - Unknown

5

435

Was Autopsy Performed

- 0 - No
- 1 - Yes
- X - Unknown

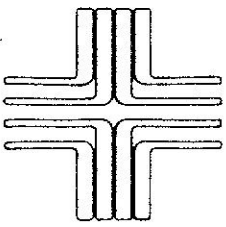
436-437

436-437

438-439

438-439

Correction of Original Area & Place Code (see cols. 246, 247)
Correction for Original State of Residence (see state code)



UCSD
MEDICAL CENTER
University of California, San Diego
Medical Center

225 Dickinson Street
San Diego, CA 92103-1990

Department of Medicine
Pulmonary and Critical Care Division

David M. Burns, M.D.
Associate Professor of Medicine
Medical Director Respiratory Therapy
Office: (619) 543-2632
FAX: (619) 543-2781

20 August 1993

Dr Michael Thun
American Cancer Society
1599 Clifton Road, NE
Atlanta, GA 30329

Dear Dr Thun:

Enclosed is the slightly revised version of the CPS1 codes, which have been used to calculate our tables of Relative Risk for various causes of mortality. The indentations are meant to show the groupings we have used to combine codes. A couple corrections were given by Larry Garfinkel, and the groupings slightly revised where counts were too low to be of value alone.

Regards,

A handwritten signature in cursive script that reads "Thomas Shanks".

Thomas Shanks

8/20/93

1-1 Corresponding ICD7 Codes

CODES	Underlying Cause of Death	CPS1 MALE	CPS1 FEMALE
00,01	Coronary Artery Disease (Heart Disease)		
00	A S H D	18834	13465
01	Coronary & Myocardial Infarction, Angina Pectoris	29088	12364
02	Rheumatic Heart Disease, Acute & Chronic	1031	1250
03	Hypertensive Heart Disease	2629	3339
07,08,09	Cerebrovascular Disease		
07	Cerebral Hemorrhage	6662	7343
08	Cerebral Thrombosis & Embolism	3800	3785
09	Other Vascular Lesions of CNS	1500	1730
10	Peripheral Vascular Disease	79	65
11	Aortic Aneurysm	1769	491
15	Hypertension	449	388
04-6,12-4,16	Other Heart & Circulatory		
04	Myocardial Degeneration	3004	3100
05	Other Heart	1842	1648
06	Coronary Pulmonale	269	192
12	Other Aneurysm (non-syphilitic)	67	80
13	Phlebitis, Pulmonary Embolism, Venous Embolism	920	861
14	Other Circulatory	357	338
16	General Arteriosclerosis	1302	1590
21,22	Peptic Ulcer		
21	Duodenal Ulcer	430	166
22	Stomach or Gastrojejunal Ulcer	391	194
24	Kidney Infection, Nephritis/Nephrosis	1350	1143
25	Cirrhosis of Liver	1108	700
28	Diabetes	1513	1724
30	Tuberculosis	194	89
31,32	Pneumonia, Influenza		
31	Respiratory Influenza, Pneumonia (independent)	2139	1788
32	Pneumonia resulting from other disease	372	294
34,3C,3D	C O P D		
34	Bronchitis	130	102
3C	Emphysema	2531	392
3D	Bronchitis & Emphysema	307	70
35	Asthma	267	158
33,36,37	Other Respiratory		
33	Pulmonary fibrosis, Fibrosis of lungs	357	213
36	Other Pulmonary, not secondary	171	35
37	Other Pulmonary, secondary	192	166
38	Suicide	1233	560
39	Violence	3325	2546

2 digit codes
CPS I

CODES	Underlying Cause of Death	CPS1 MALE	CPS1 FEMALE
40-48	Cancer, Buccal & Pharyngeal		
40	Lip	22	2
41	Tongue	120	54
42	Salivary Gland	52	45
43	Flour of Mouth	32	21
44	Other Parts of Mouth, Mouth unspecified	59	37
45	Oral Mesopharynx	44	21
46	Nasopharynx	51	16
47	Hypopharynx	29	10
48	Pharynx, Unspecified	74	14
50	Cancer, Esophagus	362	134
51	Cancer, Stomach	1224	817
53	Cancer, Colon, Large Intestine	2421	2891
54	Cancer, Rectum	830	665
55,5N	Cancer, Liver & Biliary		
55	Liver	339	307
5N	Biliary passages	128	125
5E	Gall Bladder	87	220
57	Cancer, Pancreas	1452	1091
61	Cancer, Larynx	225	25
62	Cancer, Lung & Bronchus	5574	1311
63	Cancer, Trachea and Pleura	37	17
64	Cancer, Mediastinum	18	7
70	Cancer, Breast	36	5163
71	Cancer, Cervix Uteri		621
72,74	Cancer, Uterus		
72	Corpus Uteri		340
74	Uterus, unspecified		387
73,76	Cancer, Other Female Genital		
73	Chorionepithelioma		1
76	Other & unspecified Female Genital Organs		109
75	Cancer, Ovarian		1615
77	Cancer, Prostate	2495	
78,79	Cancer, Other Male Genital		
78	Testis	27	
79	Male Genital, other & unspecified	23	
80	Cancer, Kidney	555	303
81	Cancer, Urinary Bladder & Urinary System	838	347
82,85,87	Cancer, Non-Hodgkins Lymphoma		
82	Other forms of Lymphoma	54	50
85	Mycosis Fungoides	5	5
87	Lymphosarcoma & Reticulosarcoma	673	630
83	Cancer, Multiple Myeloma	347	312
84	Cancer, Leukemia	1122	797
86	Cancer, Hodgkins Lymphoma	205	183
90	Cancer, Melanoma of skin	218	190
91	Cancer, Skin, non-melanoma	78	47
93	Cancer, Brain	659	499
94	Cancer, Thyroid	49	102
96	Cancer, Bone	77	67

CODES	Underlying Cause of Death	CPS1 MALE	CPS1 FEMALE
various	Cancer, Other		
52	Small Intestine, Duodenum	58	59
58	Peritoneum	52	50
59	Unspecified Digestive Organs	39	26
5H	Peritoneal Mesothelioma	5	10
60	Nose, Nasal Cavities	48	37
6C	Mesothelioma of Lung	7	6
69	Other respiratory	64	26
92	Eye	31	23
95	Other Endocrine Glands	34	18
97	Connective Tissue	82	95
99	Other and Unspecified	1185	1253
various	Other Diseases		
20	Benign Tumors	227	249
23	Aneurysm of aorta & other Cardiovascular Syphilis	50	12
26	Other Intestinal and Peritoneum	1133	1225
27	Cholelithiasis & Cholecystitis	272	342
29	Benign Prostatic Diseases	324	1
X1, -1	Other specified diseases	2539	2324
XX, -	ill-defined, nothing mentioned	734	550
DV	Foreign Death, cause unknown	57	77
	TOTAL	117199	88355

Per L Garfinkel, treat codes:

'1C' as '3C'

'VV' as 'DV'

GPS1 MEN - CODE1 FREQUENCIES
FOR FULL FOLLOWUP

CODE1	Frequency	Percent	Cumulative Frequency	Cumulative Percent
--	339292	74.3	339292	74.3
-1	734	0.2	340026	74.5
:=	2539	0.6	342565	75.0
C9	1	0.0	342566	75.0
DV	1	0.0	342567	75.0
VV	57	0.0	342624	75.1
00	1	0.0	342625	75.1
01	18834	4.1	361459	79.2
02	29088	6.4	390547	85.6
03	1031	0.2	391578	85.8
04	2629	0.6	394207	86.4
05	3004	0.7	397211	87.0
06	1842	0.4	399053	87.4
07	269	0.1	399322	87.5
08	6662	1.5	405984	88.9
09	3800	0.8	409784	89.8
10	1500	0.3	411284	90.1
11	79	0.0	411363	90.1
12	1769	0.4	413132	90.5
13	67	0.0	413199	90.5
14	920	0.2	414119	90.7
15	357	0.1	414476	90.8
16	449	0.1	414925	90.8
17	1302	0.3	416227	91.2
18	1	0.0	416228	91.2
20	227	0.0	416455	91.2
21	430	0.1	416885	91.3
22	391	0.1	417276	91.4
23	50	0.0	417326	91.4
24	1350	0.3	418676	91.7
25	1108	0.2	419784	91.7
26	1133	0.2	420917	92.0
27	272	0.1	421189	92.2
28	1513	0.3	422702	92.5
29	324	0.1	423026	92.6
30	2531	0.6	425557	93.2
31	307	0.1	425864	93.3
32	194	0.0	426058	93.3
33	2139	0.5	428197	93.8
34	372	0.1	428569	93.9
35	130	0.0	428926	94.0
36	297	0.0	429056	94.0
37	171	0.0	429494	94.0
38	192	0.0	429686	94.1
39	1233	0.3	430919	94.4
40	3325	0.7	434244	95.1
41	120	0.0	434266	95.1
42	522	0.0	434386	95.2
43	32	0.0	434438	95.2
44	59	0.0	434470	95.2
45	44	0.0	434529	95.2
46	51	0.0	434573	95.2
			434624	95.2

CP81 WOMEN - CODE1 FREQUENCIES
FOR FULL FOLLOWUP

CODE1	Frequency	Percent	Cumulative Frequency	Cumulative Percent
-1	506196	85.1	506196	85.1
-2	1	0.0	506197	85.1
-3	550	0.1	506747	85.2
DV	2324	0.4	509071	85.6
VV	77	0.0	509148	85.6
00	3	0.0	509151	85.6
01	13465	2.3	522616	87.9
02	12364	2.1	534980	90.0
03	1250	0.2	536230	90.2
04	3339	0.6	539569	90.8
05	3100	0.5	542669	91.3
06	1648	0.3	544317	91.6
07	192	0.0	544509	91.6
08	7343	1.2	551852	92.8
09	3785	0.6	555637	93.5
10	1730	0.3	557367	93.7
11	1	0.0	557368	93.7
12	65	0.0	557433	93.8
13	491	0.1	557924	93.8
14	80	0.0	558004	93.9
15	338	0.1	558865	94.0
16	388	0.1	559203	94.1
20	1590	0.3	559591	94.1
21	249	0.0	561181	94.4
22	166	0.0	561430	94.4
23	194	0.0	561596	94.5
24	12	0.0	561790	94.5
25	1143	0.2	561802	94.5
26	700	0.1	562945	94.7
27	1225	0.2	563645	94.8
28	342	0.1	564870	95.0
29	1724	0.3	565212	95.1
30	1	0.0	566936	95.4
31	392	0.1	566937	95.4
32	70	0.0	567329	95.4
33	89	0.0	567399	95.4
34	1788	0.3	567488	95.7
35	294	0.0	569276	95.7
36	213	0.0	569570	95.8
37	102	0.0	569783	95.8
38	158	0.0	569885	95.9
39	35	0.0	570043	95.9
40	166	0.0	570078	95.9
41	560	0.1	570244	96.0
42	2546	0.4	570804	96.4
43	2	0.0	573350	96.4
44	54	0.0	573352	96.4
45	45	0.0	573406	96.4
46	21	0.0	573451	96.5
47	37	0.0	573472	96.5
48	21	0.0	573509	96.5
49	21	0.0	573530	96.5
50	16	0.0	573546	96.5
51	10	0.0	573556	96.5

GPS1 MEN - CODE1 FREQUENCIES (WHERE VS=0)
FOR SIX YEAR FOLLOWUP

CODE1	Frequency	Percent	Cumulative Frequency	Cumulative Percent
--	212	0.5	212	0.5
-1	1112	2.4	1324	2.9
DV	6	0.0	1330	2.9
00	6664	14.6	7994	17.6
01	13160	28.9	21154	46.5
02	497	1.1	21651	47.6
03	995	2.2	22646	49.7
04	921	2.0	23567	51.8
05	594	1.3	24161	53.1
06	31	0.1	24192	53.1
07	2493	5.5	26685	58.6
08	1389	3.1	28074	61.7
09	349	0.8	28423	62.4
10	16	0.0	28439	62.5
11	647	1.4	29086	63.9
12	37	0.1	29123	64.0
13	267	0.6	29390	64.6
14	110	0.2	29500	64.8
15	204	0.4	29704	65.2
16	487	1.1	30191	66.3
20	87	0.2	30278	66.5
21	229	0.5	30507	67.0
22	166	0.4	30673	67.4
23	40	0.1	30713	67.5
24	472	1.0	31185	68.5
25	455	0.8	31640	69.3
26	373	0.8	32013	69.5
27	116	0.3	32129	70.3
28	533	1.2	32662	70.6
29	137	0.3	32799	71.7
30	802	1.8	33601	73.8
30	1	0.0	33602	73.8
31	97	0.2	33699	74.0
32	721	1.6	34420	75.6
33	3	0.0	34423	75.6
34	139	0.3	34562	75.9
35	36	0.1	34598	76.0
36	119	0.3	34717	76.3
37	52	0.1	34769	76.4
38	29	0.1	34798	76.4
39	583	1.3	35381	77.7
40	1503	3.3	36884	81.0
41	15	0.0	36899	81.0
42	49	0.1	36948	81.2
43	24	0.1	36972	81.2
44	16	0.0	36988	81.3
45	25	0.1	37013	81.3
46	20	0.0	37033	81.3
47	25	0.1	37058	81.4
48	11	0.0	37069	81.4
5E	22	0.0	37091	81.5
50	39	0.1	37130	81.6
	44	0.1	37174	81.6
	128	0.3	37302	81.9

Surgeon general
Codes used in CPS I & CPS II

TABLE 4.—Estimated relative risks for current and former smokers of cigarettes, males aged 35 years or more, 6-year (1959-65) followup of American Cancer Society 25-State study (CPS-I)

Underlying cause of death	Current smokers ^a	Former smokers ^b
All causes	1.80 (1.75-1.85) ^b	1.38 (1.33-1.42) ^b
CHD, age ≥35 (420) ^c	1.83 (1.76-1.91)	1.42 (1.34-1.49)
CHD, age 35-64 ^d (420)	2.25 (2.13-2.39)	1.56 (1.45-1.68)
CHD, age ≥65 (420)	1.39 (1.30-1.48)	1.27 (1.17-1.37)
Hypertensive Heart Disease (440-443)	1.63 (1.36-1.96)	1.19 (0.94-1.51)
Cerebrovascular Lesions, age ≥35 (330-334)	1.37 (1.25-1.49)	0.96 (0.85-1.08)
Cerebrovascular Lesions, age 35-64 (330-334)	1.79 (1.55-2.08)	1.02 (0.83-1.25)
Cerebrovascular Lesions, age ≥65 (330-334)	1.15 (1.02-1.30)	0.93 (0.80-1.08)
Aortic Aneurysm, Non-Syphilitic (451)	4.11 (3.13-5.40)	2.40 (1.73-3.34)
Ulcer, Duodenal, Gastric, and Jejunal (540-542)	3.06 (2.24-4.18)	1.49 (0.98-2.27)
Influenza and Pneumonia (480-481, 490-493)	1.82 (1.45-2.27)	1.62 (1.24-2.12)
Bronchitis and Emphysema (500-502, 527.1)	8.81 (6.40-12.13)	10.20 (7.34-14.17)
Cancer, Lip, Oral Cavity, and Pharynx (140-148)	6.33 (3.60-11.13)	2.73 (1.36-5.49)
Cancer, Esophagus (150)	3.62 (2.02-6.48)	1.28 (0.53-3.08)
Cancer, Pancreas (157)	2.34 (1.81-3.02)	1.30 (0.92-1.84)
Cancer, Larynx (161)	10.00 (3.51-28.51)	8.60 (2.87-25.74)
Cancer, Lung (162-163)	11.35 (9.10-14.15)	4.96 (3.86-6.38)
Cancer, Kidney (180)	1.84 (1.23-2.76)	1.79 (1.11-2.87)
Cancer, Bladder, Other Urinary Organs (181)	2.90 (2.01-4.18)	1.75 (1.07-2.87)

NOTE: Based upon 1,692,652 man-years of exposure among male subjects who never smoked regularly, or who smoked only cigarettes, present or past. Relative risks, estimated with respect to men who never smoked regularly, have been directly standardized to the age distribution of all man-years of exposure.
^aRefers to cigarette smoking status at enrollment (October 1959-March 1960).
^bNumbers in parentheses are 95 percent confidence intervals, computed on the assumption that the logarithm of relative risk was normally distributed.
^cAll disease codes refer to International Classification of Diseases, Seventh Revision.
^dWhen an age range is given, it refers to the age at enrollment in 1959.
 SOURCE: Unpublished tabulations, American Cancer Society.

TABLE 5.—Estimated relative risks for current cigarette smokers and for all subjects with a history of regular cigarette smoking, females aged 35 years or more, 6-year (1959-65) followup of American Cancer Society 25-State study (CPS-I)

Underlying cause of death	Current smokers ^a	Current and former smokers ^b
All causes	1.23 (1.18-1.28) ^b	1.24 (1.20-1.28) ^b
CHD, age ≥35 (420) ^c	1.40 (1.29-1.51)	1.38 (1.29-1.74)
CHD, age 35-64 ^d (420)	1.81 (1.67-1.97)	1.74 (1.61-1.89)
CHD, age ≥65 (420)	1.24 (1.11-1.39)	1.25 (1.14-1.37)
Hypertensive Heart Disease (440-443)	1.31 (1.04-1.66)	1.27 (1.04-1.55)
Cerebrovascular Lesions, age ≥35 (330-334)	1.19 (1.06-1.35)	1.26 (1.13-1.80)
Cerebrovascular Lesions, age 35-64 (330-334)	1.92 (1.69-2.18)	1.80 (1.59-2.03)
Cerebrovascular Lesions, age ≥65 (330-334)	0.97 (0.81-1.16)	1.09 (0.95-1.26)
Aortic Aneurysm, Non-Syphilitic (451)	4.64 (3.00-7.20)	3.67 (2.46-5.46)
Ulcer, Duodenal, Gastric, and Jejunal (540-542)	1.37 (0.81-2.31)	1.52 (0.96-2.41)
Influenza and Pneumonia (480-481, 490-493)	0.91 (0.59-1.41)	0.96 (0.69-1.33)
Bronchitis and Emphysema (500-502, 527.1)	5.89 (3.97-8.76)	5.85 (4.02-8.53)
Cancer, Lip, Oral Cavity, and Pharynx (140-148)	1.96 (1.14-3.39)	1.89 (1.16-3.08)
Cancer, Esophagus (150)	1.94 (1.02-3.69)	2.15 (1.09-4.23)
Cancer, Pancreas (157)	1.39 (1.04-1.86)	1.38 (1.07-1.78)
Cancer, Larynx (161)	3.81 (0.78-18.52)	3.10 (0.65-14.99)
Cancer, Lung (162-163)	2.69 (2.14-3.37)	2.59 (2.04-3.30)
Cancer, Cervix Uteri (171)	1.10 (0.83-1.47)	1.32 (1.02-1.71)
Cancer, Kidney (180)	1.43 (0.89-2.31)	1.47 (0.97-2.23)
Cancer, Bladder, Other Urinary Organs (181)	2.87 (1.74-4.74)	2.31 (1.45-3.67)

NOTE: Based upon 3,325,989 woman-years of exposure among subjects who never smoked regularly, or who smoked only cigarettes, present or past. Relative risks, estimated with respect to women who never smoked regularly, have been directly standardized to the age distribution of all woman-years of exposure.
^aRefers to cigarette smoking status at enrollment (October 1959-March 1960).
^bNumbers in parentheses are 95 percent confidence intervals, computed on the assumption that the logarithm of relative risk was normally distributed.
^cAll disease codes refer to International Classification of Diseases, Seventh Revision.
^dWhen an age range is given, it refers to the age at enrollment in 1959.
 SOURCE: Unpublished tabulations, American Cancer Society.

TABLE 6.—Estimated relative risks for current and former smokers of cigarettes, males aged 35 years or more, 4-year (1982-86) followup of American Cancer Society 50-State study (CPS-II)

Underlying cause of death	Current smokers ^a	Former smokers ^a
All causes	2.34 (2.26-2.43) ^b	1.58 (1.53-1.64) ^b
CHD, age ≥35 (410-414) ^c	1.94 (1.80-2.08)	1.41 (1.33-1.50)
CHD, age 35-64 ^d (410-414)	2.81 (2.49-3.18)	1.75 (1.55-1.99)
CHD, age ≥65 (410-414)	1.62 (1.48-1.77)	1.29 (1.20-1.38)
Other Heart Disease ^e (390-398, 401-405, 415-417, 420-429)	1.85 (1.63-2.10)	1.32 (1.18-1.48)
Cerebrovascular Lesions, age ≥35 (430-438)	2.24 (1.88-2.67)	1.29 (1.10-1.51)
Cerebrovascular Lesions, age 35-64 (430-438)	3.67 (2.51-5.36)	1.38 (0.91-2.07)
Cerebrovascular Lesions, age ≥65 (430-438)	1.94 (1.58-2.38)	1.27 (1.07-1.50)
Other Circulatory Disease ^f (440-448)	4.06 (3.08-5.35)	2.33 (1.81-3.01)
COPD (490-492, 496)	9.65 (7.00-13.30)	8.75 (6.48-11.80)
Other Respiratory Disease ^g (010-012, 480-489, 493)	1.99 (1.52-2.61)	1.56 (1.25-1.95)
Cancer, Lip, Oral Cavity, Pharynx (140-149)	27.48 (9.96-75.83)	8.80 (3.15-24.59)
Cancer, Esophagus (150)	7.60 (3.81-15.17)	5.83 (3.02-11.25)
Cancer, Pancreas (157)	2.14 (1.62-2.82)	1.12 (0.86-1.45)
Cancer, Larynx (161)	10.48 (3.61-30.43)	5.24 (1.83-14.99)
Cancer, Lung (162)	22.36 (17.77-28.13)	9.36 (7.43-11.77)
Cancer, Kidney (189)	2.95 (1.92-4.54)	1.95 (1.31-2.90)
Cancer, Bladder, Other Urinary Organs (188)	2.86 (1.85-4.44)	1.90 (1.28-2.82)

NOTE: Preliminary estimates, based upon 1,491,791 man-years of exposure among male subjects who never smoked regularly, or who smoked only cigarettes, present or past. Relative risks, estimated with respect to men who never smoked regularly, have been directly standardized to the age distribution of all man-years of exposure.

^aNumbers in parentheses are 95 percent confidence intervals, computed on the assumption that the logarithm of relative risk was normally distributed.

^bWhen an age range is given, it refers to the age at enrollment in 1982.

^cIncludes Hypertensive Heart Disease (401-404).

^dIncludes Aortic Aneurysm, Non-Syphilitic, and General Arteriosclerosis (440-441).

^eIncludes Influenza and Pneumonia (480-487).

SOURCE: Unpublished tabulations, American Cancer Society.

TABLE 7.—Estimated relative risks for current and former cigarette smokers, females aged 35 years or more, 4-year (1982-86) followup of American Cancer Society 50-State study (CPS-II)

Underlying cause of death	Current smokers ^a	Former smokers ^a
All causes	1.90 (1.82-1.98) ^b	1.32 (1.27-1.37) ^b
CHD, age ≥35 (410-414) ^c	1.78 (1.62-1.97)	1.31 (1.19-1.44)
CHD, age 35-64 ^d (410-414)	3.00 (2.50-3.59)	1.43 (1.15-1.77)
CHD, age ≥65 (410-414)	1.60 (1.42-1.80)	1.29 (1.16-1.43)
Other Heart Disease ^e (390-398, 401-405, 415-417, 420-429)	1.69 (1.44-1.99)	1.16 (1.00-1.34)
Cerebrovascular Lesions, age ≥35 (430-438)	1.84 (1.56-2.16)	1.06 (0.88-1.27)
Cerebrovascular Lesions, age 35-64 (430-438)	4.80 (3.52-6.54)	1.41 (0.94-2.13)
Cerebrovascular Lesions, age ≥65 (430-438)	1.47 (1.19-1.81)	1.01 (0.83-1.24)
Other Circulatory Disease ^f (440-448)	3.00 (2.20-4.08)	1.34 (0.95-1.90)
COPD (490-492, 496)	10.47 (7.78-14.09)	7.04 (5.33-9.30)
Other Respiratory Disease ^g (010-012, 480-489, 493)	2.18 (1.60-2.97)	1.38 (1.04-1.84)
Cancer, Lip, Oral Cavity, Pharynx (140-149)	5.59 (3.15-9.91)	2.88 (1.57-5.26)
Cancer, Esophagus (150)	10.25 (4.94-21.27)	3.16 (1.45-6.85)
Cancer, Pancreas (157)	2.33 (1.77-3.08)	1.78 (1.37-2.30)
Cancer, Larynx (161)	17.78 (3.45-91.74)	11.88 (2.46-57.34)
Cancer, Lung (162)	11.94 (9.99-14.26)	4.69 (3.86-5.70)
Cancer, Cervix Uteri (180)	2.14 (1.06-4.30)	1.94 (0.97-3.87)
Cancer, Kidney (189)	1.41 (0.86-2.30)	1.16 (0.72-1.87)
Cancer, Bladder, Other Urinary Organs (188)	2.58 (1.31-5.08)	1.85 (1.00-3.42)

NOTE: Preliminary estimates, based upon 2,418,909 woman-years of exposure among female subjects who never smoked regularly, or who smoked only cigarettes, present or past. Relative risks, estimated with respect to women who never smoked regularly, have been directly standardized to the age distribution of all woman-years of exposure.

^aNumbers in parentheses are 95 percent confidence intervals, computed on the assumption that the logarithm of relative risk was normally distributed.

^bAll disease codes refer to International Classification of Diseases, Ninth Revision.

^cWhen an age range is given, it refers to the age at enrollment in 1982.

^dIncludes Hypertensive Heart Disease (401-404).

^eIncludes Aortic Aneurysm, Non-Syphilitic, and General Arteriosclerosis (440-441).

^fIncludes Influenza and Pneumonia (480-487).

SOURCE: Unpublished tabulations, American Cancer Society.