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 on Study Code 312-313

1. Name: _____ 2. Date 16 (20-22) Index: 23-25

3. Date of Birth: Month: _____ Year: _____. (17-18) 5 yr. Group: 19 4. Present Weight (Indoor clothing): _____ lbs.

5. Height (Without shoes): _____ ft. _____ in. (26-27) 6. Race: White ☐ Negro ☐ Indian ☐ Other: _____ (28)

7. Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ (29)

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: Alive ☐ Dead ☐ ; Age (Status - 30) (31); Cancer: Yes ☐ No ☐ ; Type of Cancer 32-33

(b) Mother: Alive ☐ Dead ☐ ; Age (34); Cancer: Yes ☐ No ☐ ; Type of Cancer 35-36

c) Father's father: Alive ☐ Dead ☐ ; Age (approximate): (37); Cancer: Yes ☐ No ☐ Don't know ☐ (38)

d) Father's mother: Alive ☐ Dead ☐ ; Age (approximate): (39); Cancer: Yes ☐ No ☐ Don't know ☐ (40)

e) Mother's father: Alive ☐ Dead ☐ ; Age (approximate): (41); Cancer: Yes ☐ No ☐ Don't know ☐ (42)

f) Mother's mother: Alive ☐ Dead ☐ ; Age (approximate): (43); Cancer: Yes ☐ No ☐ Don't know ☐ (44)

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

1 (Status - 46) a) Alive ☐ or Dead ☐ ; Age (47); Cancer: Yes ☐ No ☐ ; Type of Cancer 48-49

2 (50) b) Alive ☐ or Dead ☐ ; Age (51); Cancer: Yes ☐ No ☐ ; Type of Cancer 52-53

3 (54) c) Alive ☐ or Dead ☐ ; Age (55); Cancer: Yes ☐ No ☐ ; Type of Cancer 56-57

4 (58) d) Alive ☐ or Dead ☐ ; Age (59); Cancer: Yes ☐ No ☐ ; Type of Cancer 60-61

5 (62) e) Alive ☐ or Dead ☐ ; Age (63); Cancer: Yes ☐ No ☐ ; Type of Cancer 64-65

6 (66) f) Alive ☐ or Dead ☐ ; Age (67); Cancer: Yes ☐ No ☐ ; Type of Cancer 68-69

7 (70) g) Alive ☐ or Dead ☐ ; Age (71); Cancer: Yes ☐ No ☐ ; Type of Cancer 72-73

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

1 (Status - 75) a) Alive ☐ or Dead ☐ ; Age (76); Cancer: Yes ☐ No ☐ ; Type of Cancer 77-78

2 (79) b) Alive ☐ or Dead ☐ ; Age (80); Cancer: Yes ☐ No ☐ ; Type of Cancer 81-82

3 (83) c) Alive ☐ or Dead ☐ ; Age (84); Cancer: Yes ☐ No ☐ ; Type of Cancer 85-86

4 (87) d) Alive ☐ or Dead ☐ ; Age (88); Cancer: Yes ☐ No ☐ ; Type of Cancer 89-90

5 (91) e) Alive ☐ or Dead ☐ ; Age (92); Cancer: Yes ☐ No ☐ ; Type of Cancer 93-94

6 (95) f) Alive ☐ or Dead ☐ ; Age (96); Cancer: Yes ☐ No ☐ ; Type of Cancer 97-98

4. Do you (or did you) have a twin sister? Yes ☐ No ☐ ; If "yes," indicate above which sister. (342)

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 ☐ (106) Tuberculosis ☐ (107) Bronchitis ☐ (108) Influenza ☐ (109) Laryngitis ☐ (110) Tonsillitis ☐ (111)

Asthma ☐ (112) Hay Fever ☐ (113) Dysentery ☐ (114) Stomach Ulcer ☐ (115) Duodenal Ulcer ☐ (116) Diabetes ☐ (117)

Heart Disease ☐ (118) Stroke ☐ (119) High Blood Pressure ☐ (120) Rheumatic Fever ☐ (121) Cirrhosis of Liver ☐ (122)

Gallstones ☐ (123) Arthritis ☐ (124) Polionyelitis ☐ (125) Goiter ☐ (126)

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

3. How often have you had colds (or grippe) in the last year? 1-8

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? 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 A Cough: Yes ☐ No ☐ Slight ☐ Moderate ☐ Severe ☐	10. 144 Blood in the Stool: Yes ☐ No ☐ Seldom ☐ Fairly Often ☐ Often ☐	19. 147 Unusual Bleeding from Vagina: Yes ☐ No ☐
2. 139 Sore Throat: Yes ☐ No ☐ Slight ☐ Moderate ☐ Severe ☐	11. 144 Pain or Discomfort in Lower Abdomen: Yes ☐ No ☐ Seldom ☐ Fairly Often ☐ Often ☐	20. 147 Unusual Discharge from Vagina: Yes ☐ No ☐
3. 139 Hoarseness: Yes ☐ No ☐ Slight ☐ Moderate ☐ Severe ☐	12. 144 Pain in Stomach: Yes ☐ No ☐ Seldom ☐ Fairly Often ☐ Often ☐	21. 147 Headaches: Yes ☐ No ☐ Seldom ☐ Fairly Often ☐ Often ☐
4. 142 Shortness of Breath: Yes ☐ No ☐ Slight ☐ Moderate ☐ Severe ☐	13. 145 Indigestion: Yes ☐ No ☐ Degree: 154 Slight ☐ Moderate ☐ Severe ☐	22. 148 Dizziness: Yes ☐ No ☐ Seldom ☐ Fairly Often ☐ Often ☐
5. 141 Pain or Discomfort in Chest: Yes ☐ No ☐ Slight ☐ Moderate ☐ Severe ☐	14. 145 Nausea or Vomiting: Degree: 155 Yes ☐ No ☐ Seldom ☐ Fairly Often ☐ Often ☐	23. 145 Insomnia: Yes ☐ No ☐ Degree: 155 Seldom ☐ Fairly Often ☐ Often ☐
6. 142 Difficulty in Swallowing: Yes ☐ No ☐ Slight ☐ Moderate ☐ Severe ☐	15. 145 Loss of Appetite: Yes ☐ No ☐ Degree: 156 Slight ☐ Moderate ☐ Severe ☐	24. 145 Fatigue Easily: Yes ☐ No ☐ Degree: 169 Slight ☐ Moderate ☐ Severe ☐
7. 143 Constipation: Yes ☐ No ☐ Slight ☐ Moderate ☐ Severe ☐	16. 146 Blood in the Urine: Yes ☐ No ☐ Degree: 157 Seldom ☐ Fairly Often ☐ Often ☐	25. Change in Weight: Yes ☐ No ☐ 149 If "yes," did you: Lose weight ☐ Gain weight ☐ 150 About how many pounds? _____ 151 Over what period of time? _____ 152 Did you try to bring about this change? Yes ☐ No ☐
8. 172 Diarrhea Yes ☐ No ☐ Slight ☐ Moderate ☐ Severe ☐	17. 146 Lump or Thickening in Breast: Yes ☐ No ☐	
9. 142 Recent Change in Bowel Habits: Degree: 153 Yes ☐ No ☐ Slight ☐ Moderate ☐ Severe ☐	18. 141 Unusual Discharge from Breast: Yes ☐ No ☐	26. Other Complaints: Yes ☐ No ☐ Please specify:

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 ☐ 160

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:

1. Have you ever had an injury to your breast? Yes ☐ No ☐ . If yes, which breast? _____

162 2. Many doctors recommend that women examine their breasts monthly. Do you do so? Yes ☐ No ☐

163 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 7. 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

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? _____

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? _____

181 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 foods?

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 .

206 6. When eating meat, do you avoid eating the fat? Yes ☐ No ☐

207 7. 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 _____.

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

209 9. 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 ☐

211 10. 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.

220 12. When drinking coffee, tea, or soup, do you take it: Very hot ☐ Moderately hot ☐ Luke

221 13. 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 ☐ C

Laxatives . . . . . Never ☐ Seldom ☐ C

Anti-acid medicine. . Never ☐ Seldom ☐ C

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

MISCELLANEOUS:

226 1. 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 ☐

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

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

233 234 5. How many teeth have you lost? _____

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

236 7. 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? _____

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

240 9. 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 exampl cancer of the cervix is rare in Jewish women.)

242 10. Where were you born? _____

244 11. Education: Grammar school ☐ Some high school ☐ High school graduate ☐ Some college ☐

College graduate ☐

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

REMARKS: