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Expiration Date: xx/xx/xxxx

Prostate, Lung, Colorectal and Ovarian Cancer Screening Trial

ANNUAL STUDY UPDATE and Follow-Up-Form (ASUFLF)

Participant ID: FIELD(9) *FIELD(11)* *FIELD(12)* November 23, 1998

Participant Name: FIELD(10) Study Year: FIELD(13)

If Your Name (Printed Above) Is Incorrect, Please Record Your Corrected Name Below.

Corrected Name: _____

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1. In the period from FIELD(14) **to the present, have you been diagnosed with cancer by a health care provider?**
(Do not include basal-cell or squamous-cell skin cancers.)

Yes [ ]
No [ ]
(If no, men go to item 3; women go to item 4)

2a. (*If the respondent answered Yes to Q1*) If so, what type of cancer(s) were you diagnosed with and on what date were you diagnosed?

Type/Site of Cancer (breast, lung, etc)	Date of Diagnosis
_____	_____/_____/____
_____	_____/_____/____
_____	_____/_____/____

2b. What is the name, address and phone number of the doctor who diagnosed you with this (these) cancer(s)? [IF MORE THAN ONE DOCTOR DIAGNOSED THE RESPONDENT WITH CANCER(S) LISTED IN QUESTION 2a, LIST ALL DOCTORS BELOW]. Is Dr. _____ affiliated with a larger practice? If so, what is the name of Dr. _____'s practice?

Name:_____ Phone: (____)_____
Address:_____

Name:_____ Phone: (____)_____
Address:_____

Name:_____ Phone: (____)_____
Address:_____

2c. Have you received treatment for your most recent cancer at a hospital, emergency room, or ambulatory care center affiliated with a hospital? If so, what was the name, address and phone number of the hospital? [IF MORE THAN ONE HOSPITAL, RECORD NAME, ADDRESS AND PHONE NUMBER FOR ALL HOSPITALS].

Name:_____ Phone: (____)_____

Address:_____

Name:_____ Phone: (____)_____

Address:_____

2d. Have you received treatment for your most recent cancer at a radiation treatment center? If so, what was the name, address and phone number of the center? [IF MORE THAN ONE RADIATION TREATMENT CENTER, RECORD NAME, ADDRESS AND PHONE NUMBER FOR ALL CENTERS].

Name:_____ Phone: (____)_____

Address:_____

Name:_____ Phone: (____)_____

Address:_____

2e. Are there any other doctors, hospitals, treatment centers or other healthcare providers who were involved in the treatment of your most recent cancer? [RECORD NAME , ADDRESS AND PHONE NUMBER OF ALL PROVIDERS NAMED BY RESPONDENT].

Name:_____ Phone: (____)_____

Address:_____

Name:_____ Phone: (____)_____

Address:_____

Name:_____ Phone: (____)_____

Address:_____

3. FOR MEN ONLY: In the period from FIELD(15) **to the present, have you taken the medication Proscar or Propecia (Finasteride)?** Yes [ ] No [ ]

4 What is your date of birth?

|___|___| / |___|___| / |___|___|___|___|
MONTH DAY YEAR

5. What is your Social Security Number?

|___|___|___| - |___|___| - |___|___|___|___|

The National Institutes of Health is requesting your Social Security Number under Public Health Service Act 42 USC 285a. The primary use of this information is for researchers to locate you in the future if they are unable to locate you at your home address, and to search vital records in a followup study conducted in the future. Additional disclosures of information may be: to HHS contractors, grantees, and collaborating researchers and their staff in order to accomplish the research purpose for which the records are collected; to a congressional office from the record of an individual in response to an inquiry from the congressional office made at the request of the individual; and as otherwise required by Law. **Furnishing your Social Security Number is voluntary, and you will not be denied any federal right, benefit, or privilege by your refusal to disclose it.** Rights of study participants are protected by The Privacy Act of 1974. Names and other identifiers will be separated from information provided and will not appear in any report of the study. Information provided will be combined for all study participants and report as statistical summaries.

6. What is your current primary home address and telephone number?

STREET ADDRESS APT. NO.

CITY STATE ZIP

TELEPHONE NUMBER:
( )

7. What is your work telephone number? (IF NOT APPLICABLE, CHECK HERE ☐ AND GO TO QUESTION 7)

TELEPHONE NUMBER:
( ) EXT.

8. What is your cell phone number and email address? (IF NOT APPLICABLE, CHECK HERE ☐ AND GO TO QUESTION 8)

TELEPHONE NUMBER:
( )

EMAIL ADDRESS:

(OVER)

9. If you have a vacation home or other residence, what is that address, telephone number and time of year of residence? (IF NOT APPLICABLE, CHECK HERE ☐ AND GO TO QUESTION 9)

STREET ADDRESS APT. NO.

CITY STATE ZIP

TELEPHONE NUMBER:
( )

MONTHS OF YEAR SPENT AT OTHER RESIDENCE (RECORD EXACT DATES IF POSSIBLE)
FROM: TO:

10. Please list the names of two adults who live in your household and their relationship to you. (Include your spouse, partner, children, relatives, and/or roommates.) (IF NOT APPLICABLE, CHECK HERE ☐ AND GO TO QUESTION 10)

FULL NAME OF HOUSEHOLD MEMBER RELATIONSHIP TO PARTICIPANT

1.

2.

11. What is the name, address, and telephone number of your current primary care physician or clinic? (IF NOT APPLICABLE, CHECK HERE ☐ AND GO TO QUESTION 11)

FULL NAME OF PHYSICIAN OR CLINIC		
STREET ADDRESS:		SUITE OR OFFICE NO.
CITY	STATE	ZIP
TELEPHONE NUMBER: ( )	FAX NUMBER: ( )	

12. It would be of great help to us if you could provide us with the names and addresses of two people who could give us your new address should you move. We would only contact these people if we were unable to reach you at your home address. It would be helpful to get the names of people who <u>do not</u> live with you.

1. FULL NAME	RELATIONSHIP TO YOU
STREET ADDRESS	TELEPHONE NUMBER AND PHONE TYPE ( ) _____/_____ ( ) _____/_____
CITY STATE ZIP	EMAIL ADDRESS: _____
2. FULL NAME	RELATIONSHIP TO YOU
STREET ADDRESS	TELEPHONE NUMBER AND PHONE TYPE ( ) _____/_____ ( ) _____/_____
CITY STATE ZIP	EMAIL ADDRESS: _____

13. Today's Date: _____/_____/_____
Month Day Year

14. Who completed this questionnaire? (Please check one)

[ ] Study Participant [ ] Spouse [ ] Someone else (SPECIFY)_____
Relationship

15. Comments:

_____

_____

Thank you for completing this questionnaire. Please return this form in the enclosed envelope