

May 22, 2012



[Redacted address block]

ANNUAL STUDY UPDATE

Dear [Redacted]

The time for completion of the Annual Study Update (ASU) and the Follow-up Locator Form (FLF) are upon us! We appreciate the time you have taken in past years to complete these and other study forms. Thank you for your most important continued participation in the Prostate, Lung, Colorectal and Ovarian (PLCO) Cancer Screening Trial. Enclosed are the ASU and FLF forms and a postage-paid envelope in which to return your completed forms to us.

The ASU form asks questions about your recent health and medical history. Please answer each question to the best of your ability. The contact information requested on the FLF will help us find you in future years to send you questionnaires and to notify you of study results. Please update this form with any corrections, and return it with your ASU. When you have finished completing the forms, please place them in the enclosed postage-paid envelope, and mail it to PLCO CDCC, 1600 Research Blvd. GA L60, Rockville, MD 20850.

The PLCO Central Data Collection Center (CDCC) will keep any information you give us private under the Privacy Act. Your name and identifying information will not appear in any study report. All study results will only be reported in aggregate.

Your continued participation represents a valuable contribution to the PLCO Trial, and we thank you again for your cooperation. If you have any questions or concerns please call Chris Miller, Participant Support Coordinator, at our toll-free number, (888) 886-0750.

Sincerely,

*Barbara O'Brien*

Barbara O'Brien, MPH  
Project Director, PLCO CDCC

# Prostate, Lung, Colorectal and Ovarian Cancer Screening Trial

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

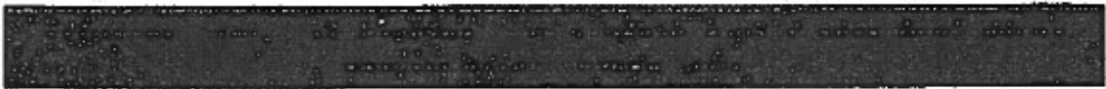
OMB No.: 0925-0407  
Expires: XX/XX/XXXX

### **PRIVACY ACT NOTIFICATION STATEMENT**

Collection of this information is authorized by The Public Health Service Act, Section 412 (42 USC 285 a-1). Rights of study participants are protected by the Privacy Act of 1974. Participation is voluntary, and there are no penalties for not participating or withdrawing from the study at any time. Refusal to participate will not affect your benefits in any way. The information collected in this study will be held in professional confidence. Names and other identifiers will be separated from information provided and will appear in any report of the study. Information provided will be combined for all study participants and reported as statistical summaries.

### **NOTIFICATION TO RESPONDENT OF ESTIMATED BURDEN**

Public reporting burden for this collection of information is estimated to average 5 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: NIH, Project Clearance Branch, 6705 Rockledge Drive, MSC 7974, Bethesda, MD 20892-7974, ATTN: PRA (0925-0407). Do not return the completed form to this address.



Participant ID:

[Redacted]

[ ]/C  
July 7, 2012

Participant Name:

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

Corrected Name: \_\_\_\_\_

1. In the period from 09/2001 to the present, have you been diagnosed with cancer by a health care provider? Yes..  No..  (If no, men go to item 3; women go to item 4)  
(Do not include basal-cell or squamous-cell skin cancers.)

2. What type of cancer was diagnosed? (Please record all cancers diagnosed during this period except basal-cell and squamous-cell skin cancers.)

Type/Site of Cancer (breast, lung, etc)	Date of Diagnosis	Hospital or Clinic Where Diagnosed
_____	<input type="text"/> / <input type="text"/> / <input type="text"/>	_____
_____	<input type="text"/> / <input type="text"/> / <input type="text"/>	_____
_____	<input type="text"/> / <input type="text"/> / <input type="text"/>	_____

What is the name, phone# and address of the physician who diagnosed the most recent cancer?

Name: \_\_\_\_\_ Phone: () -  -

Address: \_\_\_\_\_

3. FOR MEN ONLY: In the period from 09/2001 to present, have you taken the medication Proscar or Propecia (Finasteride)? Yes..  No..

4. Today's date: ..... / /   
Month Day Year

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

Study Participant  Spouse  Someone else (Specify)

Relationship: \_\_\_\_\_

6. Comments: \_\_\_\_\_

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

Prostate, Lung, Colorectal, and Ovarian Cancer Screening Trial  
FOLLOW-UP LOCATOR FORM

Participant ID: 804104-8  
Study Year: T16 / C



May 22, 2012

Today's Date: / /

Please review the information printed in the left column below to make sure it is correct. If the information in the left column is correct, check the 'OK' box. Make any additions or corrections in the right column.

FULL NAME: [REDACTED] OK

FULL NAME: \_\_\_\_\_

OTHER LAST NAMES: [REDACTED] OK

OTHER LAST NAMES: \_\_\_\_\_

NICKNAME/PREFERRED NAME: [REDACTED] OK

NICKNAME / PREFERRED NAME: \_\_\_\_\_

MAIDEN NAME: [REDACTED] OK

MAIDEN NAME: \_\_\_\_\_

DATE OF BIRTH: [REDACTED] OK

DATE OF BIRTH: \_\_\_\_\_

CURRENT HOME ADDRESS: [REDACTED] OK

HOME ADDRESS/PHONES: \_\_\_\_\_

Home Phone: [REDACTED]  
Work Phone: [REDACTED] Extension  
Cell Phone:  
Email Address:

Home Phone: \_\_\_\_\_  
Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_

VACATION HOME/OTHER RESIDENCE: 2095 ROYAL OAK AVE  
W4914 ED SEVERSON RD  
London, England OK

VACATION/OTHER ADDRESS/PHONE: \_\_\_\_\_

Phone: (414) 427-8614  
Time of Year:

Phone: \_\_\_\_\_  
Time of Year: \_\_\_\_\_



**ADULT HOUSEHOLD MEMBERS:**

Name:  
Relationship:  
Name:  
Relationship:  
Name:  
Relationship:  
Name:  
Relationship:  
Name:  
Relationship:  
Name: [REDACTED]  
Relationship: Spouse  
Name:  
Relationship:  
Name:  
Relationship:  
Name:  
Relationship:  
Name:  
Relationship:

OK   
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OK   
OK

**ADULT HOUSEHOLD MEMBERS:**

Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_



**PRIMARY CARE PHYSICIAN/CLINIC:**

Allen M. Golden  
333 Medical Rd  
333 Professional Dr  
City CO 00000

**Phone:** (000)000-0000  
**Fax:** 000  
**Physician Type:** Primary Doctor

Solomon Raymond Fife  
710 18th St  
721 W Jackson St  
Smithfield PA 15219

**Phone:** (414)492-6310  
**Fax:**  
**Physician Type:** Primary Doctor

Anacletus Jacob Agnello  
Po Box 107  
12046 Cty Tr V  
Gary PA 15213

**Phone:** (414)879-8111  
**Fax:**  
**Physician Type:** Primary Doctor

Anzy Petro Agar  
6587 Deer Path Rd  
N5387 Willow Rd  
Mckeessport PA 15963

**Phone:** (414)526-2386  
**Fax:**  
**Physician Type:** Primary Doctor

Angeline Peter Adrian  
500 Water St  
1220 Township Ave  
Puerto Rico PA 15235

**Phone:** (414)713-7975  
**Fax:**  
**Physician Type:** Primary Doctor

Annetta Algart Adametz  
Continental Manor  
5044 N Biron Dr  
Jenner Twp. Somerset Co. PA 15135

**Phone:** (414)913-2769  
**Fax:**  
**Physician Type:** Primary Doctor

Alverda Jeanine Acton  
21897 Spirit Lk Rd W  
413 Main  
Louisville PA 15143

**Phone:** (414)547-6350  
**Fax:**

**PRIMARY CARE PHYSICIAN/CLINIC:**

OK

**Phone** \_\_\_\_\_  
**Fax:** \_\_\_\_\_  
**Physician Type:** \_\_\_\_\_

OK

**Phone** \_\_\_\_\_  
**Fax:** \_\_\_\_\_  
**Physician Type:** \_\_\_\_\_

OK

**Phone** \_\_\_\_\_  
**Fax:** \_\_\_\_\_  
**Physician Type:** \_\_\_\_\_

OK

**Phone** \_\_\_\_\_  
**Fax:** \_\_\_\_\_  
**Physician Type:** \_\_\_\_\_

OK

**Phone** \_\_\_\_\_  
**Fax:** \_\_\_\_\_  
**Physician Type:** \_\_\_\_\_

OK

**Phone** \_\_\_\_\_  
**Fax:** \_\_\_\_\_  
**Physician Type:** \_\_\_\_\_

OK

**Phone** \_\_\_\_\_  
**Fax:** \_\_\_\_\_



**PRIMARY CARE PHYSICIAN/CLINIC:**

**Physician Type:** Primary Doctor

Aldo Georgine Acheson  
N15318 Cty Rd O  
3811 Griffith Ave  
Farrel PA 16117

**Phone:** (414)863-8579

**Fax:**

**Physician Type:** Primary Doctor

Ahmed Vincent Abbruzzese  
5554 Easy St  
663 S Waupaca Apt 5  
Juniata PA 15650

**Phone:** (414)609-9902

**Fax:**

**Physician Type:** Primary Doctor

Aldo Walter Abbondanza  
Po Box 394  
930 16th St N  
Gibsonia PA 15226

**Phone:** (414)986-7058

**Fax:**

**Physician Type:** Primary Doctor

Al Viola Adam  
1420 Woodbine  
Rt 1, Box 304  
Shreveport AK

**Phone:** (414)299-8321

**Fax:**

**Physician Type:** Primary Doctor

**PRIMARY CARE PHYSICIAN/CLINIC:**

**Physician Type:** \_\_\_\_\_

OK

**Phone** \_\_\_\_\_

**Fax:** \_\_\_\_\_

**Physician Type:** \_\_\_\_\_

OK

**Phone** \_\_\_\_\_

**Fax:** \_\_\_\_\_

**Physician Type:** \_\_\_\_\_

OK

**Phone** \_\_\_\_\_

**Fax:** \_\_\_\_\_

**Physician Type:** \_\_\_\_\_

OK

**Phone** \_\_\_\_\_

**Fax:** \_\_\_\_\_

**Physician Type:** \_\_\_\_\_



In the past, you provided us with the names and addresses of the following people who could give us your new address if you move. It is helpful for us to get the names of people who do not live with you. Please confirm that these people are the best contacts for you.

**CONTACTS:**

[Redacted Name]  
[Redacted Address]  
[Redacted City, State, Zip]

Phone 1: [Redacted] 303-1537

Phone 2:

Email Address:

Relationship: Son

OK

**CONTACTS:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone 1: \_\_\_\_\_ Type: \_\_\_\_\_

Phone 2: \_\_\_\_\_ Type: \_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

OK

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone 1: \_\_\_\_\_ Type: \_\_\_\_\_

Phone 2: \_\_\_\_\_ Type: \_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

OK

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone 1: \_\_\_\_\_ Type: \_\_\_\_\_

Phone 2: \_\_\_\_\_ Type: \_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

OK

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone 1: \_\_\_\_\_ Type: \_\_\_\_\_

Phone 2: \_\_\_\_\_ Type: \_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

OK

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone 1: \_\_\_\_\_ Type: \_\_\_\_\_

Phone 2: \_\_\_\_\_ Type: \_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

OK

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone 1: \_\_\_\_\_ Type: \_\_\_\_\_

Phone 2: \_\_\_\_\_ Type: \_\_\_\_\_

Email Address: \_\_\_\_\_

Relationship: \_\_\_\_\_

Phone 1:

Phone 2:

Email Address:

Relationship:

Phone 1:

Phone 2:

Email Address:

Relationship:

Phone 1:

Phone 2:

Email Address:

Relationship:

[Redacted Name]  
[Redacted Address]  
[Redacted City, State, Zip]

Phone 1: [Redacted]

Phone 2:

Email Address:

Relationship: Daughter

Phone 1:

Phone 2:

Email Address:

Relationship:





In the past, you provided us with the names and addresses of the following people who could give us your new address if you move. It is helpful for us to get the names of people who do not live with you. Please confirm that these people are the best contacts for you.

**CONTACTS:**

Phone 1:  
Phone 2:  
Email Address:  
Relationship:

OK

**CONTACTS:**

Phone 1: \_\_\_\_\_ Type: \_\_\_\_\_  
Phone 2: \_\_\_\_\_ Type: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Relationship: \_\_\_\_\_

OK

Phone 1:  
Phone 2:  
Email Address:  
Relationship:

Phone 1: \_\_\_\_\_ Type: \_\_\_\_\_  
Phone 2: \_\_\_\_\_ Type: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Relationship: \_\_\_\_\_

OK

Phone 1:  
Phone 2:  
Email Address:  
Relationship:

Phone 1: \_\_\_\_\_ Type: \_\_\_\_\_  
Phone 2: \_\_\_\_\_ Type: \_\_\_\_\_  
Email Address: \_\_\_\_\_  
Relationship: \_\_\_\_\_

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