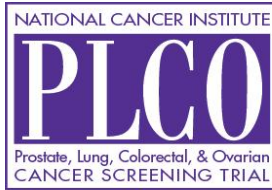
Attachment 1
Annual Study Update Form



May 22, 2012

ANNUAL STUDY UPDATE

Dear .

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 **strictly confidential.** 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
Expiration Date: XX/XX/20XX

Collection of this information is authorized by The Public Health Service Act, Section 411 (42 USC 285 a). 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 private to the extent provided by law. Names and other identifiers will not appear in any report of the study. Information provided will be combined for all study participants and reported as summaries. You are being contact by mail to complete this instrument so that we can learn about changes in your health and contact information.

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 mat 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.

Version Date: 10/99 Expiration Date: 09/14 Form Approved OMB#: 0925-0407

Participant ID: [ ]/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 (Month / Day / Year)	Hospital or Clinic Where Diagnosed
	__/__/__	
	__/__/__	
	__/__/__	

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.

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

Participant ID:
Study Year:

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:	OK ☐	**FULL NAME:**
OTHER LAST NAMES:	OK ☐	**OTHER LAST NAMES:**
NICKNAME/PREFERRED NAME:	OK ☐	**NICKNAME / PREFERRED NAME:**
MAIDEN NAME:	OK ☐	**MAIDEN NAME:**
DATE OF BIRTH:	OK ☐	**DATE OF BIRTH:**
CURRENT HOME ADDRESS:	OK ☐	**HOME ADDRESS/PHONES:**
Home Phone:		**Home Phone:**
Work Phone: **Extension**		**Work Phone:** **Ext:**
Cell Phone:		**Cell Phone:**
Email Address:		**Email Address:**
VACATION HOME/OTHER RESIDENCE:	OK ☐	**VACATION/OTHER ADDRESS/PHONE:**
Phone:		**Phone:**
Time of Year:		**Time of Year:**

ADULT HOUSEHOLD MEMBERS:

Name:
Relationship: OK ☐

Name:
Relationship: OK ☐

Name:
Relationship: OK ☐

Name:
Relationship: OK ☐

Name:
Relationship: OK ☐

Name:
Relationship: OK ☐

Name:
Relationship: OK ☐

Name:
Relationship: OK ☐

Name:
Relationship: OK ☐

Name:
Relationship: 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:		**PRIMARY CARE PHYSICIAN/CLINIC:**
	OK ☐	
Phone: **Fax:** **Physician Type:**		**Phone** ___ **Fax:** ___ **Physician Type:** ___
	OK ☐	
Phone: **Fax:** **Physician Type:**		**Phone** ___ **Fax:** ___ **Physician Type:** ___
	OK ☐	
Phone: **Fax:** **Physician Type:**		**Phone** ___ **Fax:** ___ **Physician Type:** ___
	OK ☐	
Phone: **Fax:** **Physician Type:**		**Phone** ___ **Fax:** ___ **Physician Type:** ___
	OK ☐	
Phone: **Fax:** **Physician Type:**		**Phone** ___ **Fax:** ___ **Physician Type:** ___
	OK ☐	
Phone: **Fax:** **Physician Type:**		**Phone** ___ **Fax:** ___ **Physician Type:** ___
	OK ☐	
Phone: **Fax:**		**Phone** ___ **Fax:** ___

PRIMARY CARE PHYSICIAN/CLINIC:	PRIMARY CARE PHYSICIAN/CLINIC:
Physician Type:	Physician Type:
OK ☐	
Phone:	Phone
Fax:	Fax:
Physician Type:	Physician Type:
OK ☐	
Phone:	Phone
Fax:	Fax:
Physician Type:	Physician Type:
OK ☐	
Phone:	Phone
Fax:	Fax:
Physician Type:	Physician Type:
OK ☐	
Phone:	Phone
Fax:	Fax:
Physician Type:	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:

Phone 1:
Phone 2:
Email Address:
Relationship:

OK ☐

CONTACTS:

Phone 1: ______ **Type:** ______
Phone 2: ______ **Type:** ______
Email Address: ______
Relationship: ______

Phone 1:
Phone 2:
Email Address:
Relationship:

OK ☐

Phone 1: ______ **Type:** ______
Phone 2: ______ **Type:** ______
Email Address: ______
Relationship: ______

Phone 1:
Phone 2:
Email Address:
Relationship:

OK ☐

Phone 1: ______ **Type:** ______
Phone 2: ______ **Type:** ______
Email Address: ______
Relationship: ______

Phone 1:
Phone 2:
Email Address:
Relationship:

OK ☐

Phone 1: ______ **Type:** ______
Phone 2: ______ **Type:** ______
Email Address: ______
Relationship: ______

Phone 1:
Phone 2:
Email Address:
Relationship:

OK ☐

Phone 1: ______ **Type:** ______
Phone 2: ______ **Type:** ______
Email Address: ______
Relationship: ______

Phone 1:
Phone 2:
Email Address:
Relationship:

OK ☐

Phone 1: ______ **Type:** ______
Phone 2: ______ **Type:** ______
Email Address: ______
Relationship: ______

Participant ID:
Study Year:

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CONTACTS:

OK ☐

Phone 1:
Phone 2:
Email Address:
Relationship:

OK ☐

Phone 1:
Phone 2:
Email Address:
Relationship:

OK ☐

Phone 1:
Phone 2:
Email Address:
Relationship:

CONTACTS:

____
____
____
____

Phone 1: ____________ **Type:** ________
Phone 2: ____________ **Type:** ________
Email Address: ________________
Relationship: ________________

____
____
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____

Phone 1: ____________ **Type:** ________
Phone 2: ____________ **Type:** ________
Email Address: ________________
Relationship: ________________

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____

Phone 1: ____________ **Type:** ________
Phone 2: ____________ **Type:** ________
Email Address: ________________
Relationship: ________________

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