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Health behaviors and cancer screening among Californians with a family history of cancer

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Abstract

Purpose—The purpose of this study is to compare health behaviors and cancer screening among Californians with and without a family history of cancer.

Methods—We analyzed data from the 2005 California Health Interview Survey to ascertain cancer screening test use and to estimate the prevalence of health behaviors that may reduce the risk of cancer. We used logistic regression to control for demographic factors and health care access.

Results—Women with a family history of breast or ovarian cancer were more likely to be up-to-date with mammography compared to women with no family history of cancer (OR = 1.69, 95% CI [1.39, 2.04]); their health behaviors were similar to other women. Men and women with a family history of colorectal cancer were more likely to be up-to-date with CRC screening compared to individuals with no family history of cancer (OR=2.77, 95% CI [2.20, 3.49]), but were less likely to have a BMI < 25 kg/m² (OR=0.80, 95% CI [0.67, 0.94]).

Conclusion—Innovative methods are needed to encourage those with a moderate to strong familial risk for breast cancer and colorectal cancer to increase their physical activity levels, strive to maintain a healthy weight, quit smoking, and reduce alcohol use.

Keywords

family medical history; behavioral risk factors; colorectal neoplasms; breast neoplasms; cancer screening

INTRODUCTION

Hereditary breast and ovarian cancer (HBOC) syndrome and Lynch syndrome increase individual risk for breast, ovarian, colorectal (CRC), and uterine cancers.¹ Inherited mutations associated with these syndromes account for up to 10% of each of these cancers in

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the United States.¹ In addition to these genetic syndromes, family medical history (FMH) is an established risk factor for blood relatives to develop the same or related cancers. Along with shared genetic risk factors, families may also share the same environment and exposures, and similar health behaviors which lead to increased cancer risk.

Nearly 8% of people in the United States report having a first-degree relative with a history of breast cancer; 7.1%, with a history of lung cancer; 5.0%, with a history of CRC; 4.7%, with a history of prostate cancer; and 1.8%, with a history of ovarian cancer.² Having a first-degree relative with breast cancer increases an individual's risk two-fold.³ Similarly, having a first-degree relative diagnosed with CRC doubles a person's risk.⁴ Convincing evidence demonstrates that alcohol consumption increases risk for both pre- and postmenopausal breast cancers⁵ and CRC.⁶ Obesity increases risk for endometrial,⁷ CRC,⁶ and postmenopausal breast cancer.⁵ Regular physical activity is associated with a lower risk of colon cancer,⁸ and likely reduces risk for endometrial cancer⁷ and breast cancer in postmenopausal women.⁵ Tobacco use can increase risk for CRC,⁹ and may modestly increase breast cancer risk based on findings from recent large prospective cohort studies.¹⁰ Fruit and vegetable consumption^{5,11} and dietary intake of fat⁵ likely have little effect on breast cancer risk. Although fruit and vegetable consumption has not been consistently linked with CRC,¹¹ consumption of red and processed meat may increase risk, while high fiber diets may lower risk.⁶ Approximately 23% of CRC cases could be prevented through the combination of no smoking, regular physical activity, limiting alcohol use, and maintaining a healthy diet and waist circumference.¹²

Modification of dietary and lifestyle behaviors can reduce the risk of breast and CRC even in individuals with FMH of these cancers.^{13,14} While cancer screening test use is higher in persons with FMH of CRC^{15,16} and breast cancer¹⁶; less is known about their health behaviors at the population-level.¹⁷ Additionally, few studies have addressed how FMH can be used to motivate individuals to adopt and maintain healthy lifestyles to reduce disease risk.¹⁸

The aim of this study is to examine health behaviors (maintenance of healthy weight, prudent alcohol use, regular physical activity, fruit and vegetable consumption, and no smoking) of Californians who report having one or more family members with a history of cancer (primarily in first-degree relatives), compared with health behaviors of individuals who report no FMH of cancer in a first-degree relative, with emphasis on family history of breast or ovarian cancers, CRCs, and FMH of early onset cancer in a first-degree relative. CRC and breast cancer screening test use is also compared among these individuals. We utilized the 2005 California Health Interview Survey (CHIS), a population-based survey to examine these factors.

MATERIALS AND METHODS

Data Source

Adult and family health history public use data files of the 2005 CHIS (the most current data at the time this study was conducted) were obtained. CHIS is a population-based, random-digit-dialed telephone survey conducted every 2 years with non-institutionalized California

resident households, to obtain information on health behaviors, health care access, insurance coverage, health status, and a variety of other health-related topics. The CHIS uses a two-stage geographically stratified sampling design and interviews are conducted in five languages to reach California's diverse population. More information on CHIS methodology can be obtained at <http://www.chis.ucla.edu/designs-methods.html>. In 2005, over 45,000 households participated in the CHIS with an overall household response rate of 29.5%. This response rate is based on the American Association for Public Opinion Research (AAPOR)'s overall response rate definition, which includes partially completed questionnaires (http://www.chis.ucla.edu/pdf/CHIS2005_method4.pdf).

In the 2005 CHIS adult survey, Californians aged 18–64 years were asked about their FMH of any cancer among first-degree (mother, father, brother(s), sister(s), and children) and second-degree (grandparents, aunts, and uncles) relatives. Distinctions were made between half and full siblings. For each affected family member, respondents were asked about the specific type of cancer (breast, ovarian, uterine/endometrial, or colon/rectum for female family members, and breast, colon/rectum, or prostate cancer for male family members) and if the affected family member was under age 50 years at the time of his or her diagnosis.

Inclusion Criteria

The adult CHIS public-use dataset included 43,020 adults. We excluded 9,833 adults aged 65 years because they were not asked their FMH of cancer. We excluded an additional 2,501 respondents because they had a personal history of any cancer, and 426 additional respondents who did not know if they had a first-degree family member with a history of cancer. This left 30,260 respondents for the analysis.

We created indicator variables (Table 1) based on responses to the FMH module regarding type of cancer and the affected family member to classify respondents who would be at moderate to strong risk for cancer based on their FMH profile (degree of relation, number, age of affected relatives): 1) Any family history of cancer (primarily in a first-degree relative); or 2) FMH of CRC; 3) FMH of breast or ovarian cancer; and 4) FMH history of CRC, breast, prostate, ovarian, or endometrial cancer in a first-degree relative diagnosed under age 50 (i.e. early onset), which included examining the subpopulations of FMH of CRC and breast or ovarian cancer separately in descriptive analyses only. We included ovarian cancer history and second-degree relatives in the same lineage to better classify women at moderate-to-strong risk for developing familial breast cancer.¹⁹ Of 18,501 respondents with no FMH of cancer in a first-degree relative, 251 women had female breast or ovarian cancer in two or more second-degree relatives in the same lineage or a second-degree male relative with breast cancer, and 83 respondents without a first-degree relative diagnosed with cancer had two or more second-degree relatives in the same lineage with CRC. These respondents with FMH of breast, ovarian, or CRC were grouped with respondents having a first-degree relative with cancer. This left 12,026 respondents with a FMH of cancer, and 18,234 without.

Variables and Statistical Analysis

We examined the following demographic or health care access variables: sex, age group, race/ethnicity (based on race/ethnic group respondent most identified with), household income, education level, health insurance coverage, marital status, general health condition, having a condition that substantially limits one or more basic physical activities, and having a usual place to go when sick or in need of health advice. We included the following health behaviors: eating five or more servings of fruits and vegetables/ day (marker of a healthy diet/ weight management aid),²⁰ regular physical activity (20 minutes of vigorous physical activity 3 days in the past week or 30 minutes of moderate physical activity 3 days in the past week), smoking status (current, former/ never smoked regularly), binge drinking in the past month (5 drinks per occasion for men and 4 drinks per occasion for women), and self-reported body mass index (BMI) (underweight/normal: <25.0 kg/m², overweight/obese: 25.0 kg/m² or higher).

Respondents were considered up-to-date with cancer screening tests if they were screened according to 2005 United States Preventive Services Task Force (USPSTF) guidelines. We classified respondents aged 50 years as being up-to-date with CRC screening if at least one of the following conditions were met: fecal occult blood test (FOBT) received within the past year, sigmoidoscopy within the past 5 years, or colonoscopy within the past 10 years. Women aged 40 years were considered up-to-date with screening for breast cancer if they had received mammography within the past 2 years. For women who were up-to-date with mammography screening, we examined the reason women provided for receiving their last mammogram. For men and women aged 40 years with FMH of CRC, we also assessed receipt of colonoscopy within the past 5 years and receipt of any CRC screening test within appropriate time intervals for average-risk individuals because more stringent screening is recommended in this population.²¹ Because women with FMH profiles of early onset breast or ovarian cancer may be encouraged to initiate breast cancer screening at an earlier age than average-risk women,²² we examined the prevalence of women aged 30 years receiving a mammogram within the past year.

We used SAS v9.2 (SAS Institute, Cary, NC) and SAS callable SUDAAN release 10 (Research Triangle Institute, Research Triangle Park, NC) to conduct all analyses to account for the complex sampling design of CHIS. In both the descriptive and multivariate logistic regression analyses, the jackknife method was used to calculate variance, because replicate weights were provided to accurately calculate variance due to the complex sampling design of the CHIS. All estimates were weighted to produce population estimates that account for the probability of selection and factors associated with survey design and administration (e.g., non-response and under-coverage due to lack of a residential landline).

We conducted a descriptive analysis comparing respondents with each of the different FMH of cancer profiles to persons without a FMH of cancer, to obtain percentages and standard errors on demographic characteristics, health behaviors of interest, and cancer screening test use. *P* values were obtained from Rao-Scott chi-square tests. We conducted a multivariate logistic regression analysis, building separate logistic regression models with the following seven outcomes as dichotomous variables (yes vs. no): 1) eating five or more servings of

fruits and vegetables per day; 2) engaging in regular physical activity; 3) not a current smoker; 4) BMI < 25.0 kg/m²; 5) no alcoholic binge drinking in the past month (i.e., the month preceding survey), and 6) up-to-date with CRC screening; and 7) breast cancer screening. Models were run separately for any FMH of cancer, FMH of breast or ovarian cancer (women only), FMH of CRC, and FMH of early onset cancer in a first-degree relative to obtain odds ratios and 95% confidence intervals for the outcomes of interest adjusted for demographic characteristics and health care access. The referent group in all models was respondents without FMH of cancer. We used a backwards elimination approach to eliminate nonsignificant ($P < 0.05$) covariates from all models (with the exception of age, race/ethnicity, and having a usual healthcare provider). Covariates initially included in the health behavior models were: age, sex (except for the FMH of breast or ovarian cancer model), race/ethnicity, household income, health insurance status, education level, having a usual health care provider, having a condition that substantially limits one or more basic physical activities, marital status, and general health status. Covariates initially included in the cancer screening models were: age, race/ethnicity, household income, health insurance status, education level, having a usual health care provider, marital status, and sex (CRC screening models).

RESULTS

Prevalence of FMH of cancer was higher among women, older age groups, and more educated, higher income individuals (Table 2). Non-Latino whites and American Indians/Alaska Natives (42.8% and 37.5%, respectively) reported a higher prevalence of any FMH of cancer, while Asian/Pacific Islanders and Latinos had the lowest prevalence (22.1%, and 17.6%, respectively; $P < 0.0001$). Prevalence of FMH of cancer was more often reported by individuals with health care coverage and who had a usual health care provider.

Nearly 45% of men and women with FMH of CRC consumed five or more servings of fruits and vegetables per day compared to 49.5% of men and women without FMH of cancer (Table 3; $P = 0.0057$). After adjustment for demographic characteristics and health care access, men and women with FMH of CRC were 16% less likely to consume five or more servings of fruits and vegetables per day (OR=0.84, 95% CI [0.73, 0.96]). After adjustment for demographic characteristics and health care access in multivariate models, no significant differences were found for binge drinking. Men and women with FMH of any cancer had lower rates of a BMI < 25.0 kg/m² compared to men and women with no FMH of cancer (42.6% vs. 45.7%, respectively; $P = 0.0001$); results are similar for persons with FMH of CRC (39.4%, $P = 0.0011$) and FMH of early onset cancer (41.6%, $P = 0.0074$). After adjustment for demographic characteristics and health care access, men and women with FMH of any cancer were 9% less likely to report being normal/underweight compared to persons without FMH of cancer (OR=0.91, 95% CI [0.85, 0.98]), and men and women with FMH of CRC were 20% less likely to report being normal/underweight (OR=0.80; 95% CI [0.67, 0.94]).

Among men and women aged ≥ 50 years with FMH of CRC, 71.5% were up-to-date with CRC screening, compared to 44.5% of persons without FMH of cancer ($P < 0.0001$). After adjustment for demographic characteristics and health care access, men and women with

FMH of CRC were nearly 2.8 times more likely to be up-to-date (OR=2.77; 95% CI [2.20, 3.49]); while persons with FMH of any cancer and persons with FMH of early onset cancer were more likely to be up-to-date compared to persons without FMH of cancer (OR=1.33, 95% CI [1.17, 1.51] and OR=1.37, 95% CI [1.12, 1.66], respectively). Nearly 58% of men and women aged 40 – 64 years with FMH of CRC and 53% with FMH of early onset CRC were up-to-date at screening intervals recommended for the average-risk population ($P < 0.0001$ and $P < 0.0001$, respectively). Among this age group, 42.0% of persons with FMH of early onset CRC had received a colonoscopy within the past five years ($P < 0.0001$). These findings were nearly identical to all persons with FMH of CRC.

Although women with FMH of breast or ovarian cancer reported higher levels of regular physical activity, lower rates of not being a current smoker, and lower rates of normal/underweight status compared to women without FMH of cancer, these differences for physical activity, smoking status, and weight disappeared after adjustment for demographic characteristics and health care access (Table 4).

Eighty-five percent of women aged 40 – 64 years with FMH of breast or ovarian cancer had received a mammogram within the past two years, compared to 73.7% of women without FMH of cancer ($P < 0.0001$). After adjustment for demographic characteristics and health care access, women with FMH of breast or ovarian cancer were nearly 1.7 times more likely to be up-to-date compared to women without FMH of cancer (OR=1.69, 95% CI [1.39, 2.04]). Among women aged 30 – 64 years who had received a mammogram within the past two years, 33.2% of women with FMH of breast or ovarian cancer and 41.7% with FMH of early onset breast or ovarian cancer reported that the reason for the test was due to family history, compared to 2.6% of women with no FMH of any cancer ($P < 0.0001$). Younger women (aged 30 – 49 years) more frequently reported family history as a reason for the test than older women (data not shown). Fifty-six percent of women aged 30 – 64 years with FMH of early onset breast or ovarian had received a mammogram within the past year ($P < 0.0001$). Rates were highest among women aged 50 – 59 years (78.7%) compared to women aged 30 – 39 years and 40 – 49 years (28.4% and 55.5%, respectively; data not shown).

DISCUSSION

In this large, population-based study, we found that men and women with an FMH of CRC were less likely to maintain a healthy weight and consume 5 or more servings of fruits and vegetables per day (which increases risk for CRC), than those without FMH of cancer. Conversely, we found that men and women with FMH were more likely to be up-to-date with cancer screenings than those without. To our knowledge, these weight-related findings are some of the first to be presented for individuals with cancer FMH. Additionally, our study, being one of only a few that is population-based, strengthens the literature on all health behaviors and cancer screenings in those with FMH of cancer.

While our findings on healthy weight among individuals with FMH of CRC appear to be novel, our health behavior findings on physical activity and alcohol use are generally similar to those from other recent studies.^{17,23} In our study, women with FMH of breast or ovarian

cancer had health behaviors similar to women without FMH of cancer. Other studies have found similar results,^{24,25} although some studies have found more intense or higher levels of physical activity in women with a family history of breast cancer,^{26–28} or greater practice of health behaviors was observed, compared with the general population.²⁶ In some of these studies, data were drawn on women of higher education or socioeconomic status;^{26,28} therefore, these findings may not be generalizable to other populations, including ours.

Taken together, our health behavior findings indicate that there may be missed opportunities to improve the health of a population that is at increased risk of cancer. FMH of cancer represents a complex interaction between genes and environment. Since only a small fraction of cancer cases are attributable to hereditary syndromes, clinicians should consider health behavior counseling when they encounter patients with FMH of cancer, because they may be exhibiting the same negative behaviors that likely contributed to their relative's cancer. Studies have shown that persons with FMH of breast or CRC are more likely to receive recommendations from health care providers to improve health behaviors, but the overall number receiving these recommendations may be low.^{17,29} In one study, women with FMH of breast cancer were more likely to report making one or more health behavior changes because of a recently diagnosed first-degree relative.³⁰ Persons with a FMH of CRC may also be willing to make health behavior changes and to follow through,¹⁷ but awareness of risk factors for CRC may be low.³¹ Additionally, awareness of FMH of cancer may not always translate into positive health behaviors. Conversely, it may place too much emphasis on genetic susceptibility.³² In this study, we were unable to assess if our study findings were due to a lack of awareness of risk factors for breast and CRC. Regardless, patients with an FMH of cancer may benefit from a targeted approach to improving their health behaviors. Findings from the Family Healthware Impact trial indicate modest increases in physical activity levels after a targeted intervention.³³

Results from our cancer screening analysis showed that women with FMH of breast or ovarian cancer were nearly 1.7 times more likely to be up-to-date with mammography screening compared to women without FMH of cancer, but nearly 15% were not up-to-date with recommendations for women at average risk for breast cancer. Although men and women with FMH of CRC were 2.8 times more likely to be recently screened compared to men and women without FMH of cancer, nearly 29% were not currently up-to-date with recommendations for average-risk individuals. Nearly 42% of women with FMH of early onset breast or ovarian cancer reported that the reason for their last mammogram was due to FMH of cancer. Although sample sizes were small, we found this varied considerably by age. Younger women more frequently reported family history as a reason compared to older women. Our findings of increased cancer screening test use among Californians with FMH of cancer are similar to other studies that examine this.^{15,16} These findings indicate that many patients and their health care providers recognize the increased risk conferred by FMH of cancer. However, screening for CRC is suboptimal for men and women with FMH of early onset CRC; 58% had not received a colonoscopy within the past 5 years. While having a FMH of cancer did increase the odds of breast and CRC screening, a considerable portion of individuals in our study with FMH of early onset CRC, breast or ovarian cancer were not appropriately screened considering their FMH profile. Although sample sizes were small, only 28% of women aged 30 – 39 years with a FMH of early onset breast or ovarian cancer

had received a mammogram within the past year (data not shown). These study findings may be due in part to the challenges of collecting FMH of cancer in the clinical setting. Primary care clinicians are often the first healthcare providers to ascertain family health histories and refer patients for cancer screening.³⁴ Barriers to collecting the FMH include lack of time,^{18,34} limited tools for use in primary care,³⁴ concerns about validity of self-reported FMH,³⁵ and lack of clear guidelines to assist in collecting, interpreting, and using FMH for disease risk management.³⁶ Some investigators have indicated that the accuracy of self-reports of FMH of cancer may be improved if tools rather than interviews are used,³⁴ and if information is collected outside of clinical visits, where it could be checked with relatives.³⁵ The US Surgeon General's family health history initiative encourages Americans to learn more about their family's health history, and a computerized tool is available to record family health information (available at <http://www.hhs.gov/familyhistory/>). Guidelines on how to systematically assess risk of cancer or use the information to guide prevention efforts is limited, but some resources are available to providers. The American Medical Association provides resources and tools to assist providers in collecting histories (available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-science/genetics-molecular-medicine/family-history.page?>). As electronic medical records (EMRs) are increasingly adopted by primary care physicians, existing tools must be able to interface or be integrated into these systems. However, EMRs may allow more extensive FMHs to be assembled more easily.³⁷

This study is subject to some limitations. Currently, standardized definitions do not exist for moderate and high risk FMH of cancer profiles, so some respondents may have been misclassified. CHIS is a cross-sectional telephone survey, so self-reported demographic, health behavior, FMH, and cancer screening information may all be subject to social desirability bias. FMH of cancer was not verified against medical records or cancer registry data, so under- or over-reporting was possible, and this likely occurred with endometrial cancer, which is not reported as accurately as other cancer sites.³⁸ Foreign-born status may partially explain racial and ethnic differences in reporting FMH of cancer.³⁹ However, accurate self-reporting of family history of cancer in first-degree relatives for breast, CRC, and prostate cancer is high.³⁸ Our results for California are not generalizable to the overall United States population. Because we examined seven different outcomes for several different cancer FMH profiles, some findings may be due to chance alone. Despite these limitations, few population-based surveys collect data on FMH of cancer that includes age of onset and second-degree relatives. CHIS is a large health survey from a racially and ethnically diverse population, therefore most of our analyses were not constrained by small sample sizes.

Conclusion

Individuals with FMH of breast, ovarian, or CRC cancers are at higher risk of developing these same cancers, and would benefit from adopting healthier lifestyles that may reduce their own cancer risk. Innovative methods may be needed by California health care providers to raise awareness of behavioral risk factors and motivate these individuals to adopt healthier lifestyles.

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Table 1

Indicator variables, based on responses to the family history module regarding type of cancer and the affective family member

1	History of any cancer in
	<input type="radio"/> A first-degree relative, or
	<input type="radio"/> History of colorectal cancer (described below)
	<input type="radio"/> History of breast or ovarian cancer (described below)
2	History of colorectal cancer in
	<input type="radio"/> A first-degree relative, or
	<input type="radio"/> Two or more second-degree relatives in the same lineage.
3	History of female breast or ovarian cancer in
	<input type="radio"/> One or more first-degree relatives;
	<input type="radio"/> Two or more second-degree relatives in the same lineage; or
	<input type="radio"/> Any first- or second-degree male relative with breast cancer.
4	History of colorectal, breast, prostate, ovarian, or endometrial cancer in a first-degree relative diagnosed under age 50.

Prevalence^a of family medical history of cancer by demographic characteristics of Californians aged 18–64 years, California Health Interview Survey, 2005

TABLE 2

Family Medical History of Cancer									
Characteristic	Sample size (unweighted)	Men and women				Women only			
		None, n=18,234	Any, n=12,026	Early onset in first-degree relative (any) n=2,145 ^b	Colorectal cancer n=1,538	None n=10,118 ^c	Breast or ovarian cancer n=2,357 ^c		
		% (SE)	% (SE)	% (SE)	% (SE)	% (SE)	% (SE)	<i>p</i> ^d	<i>p</i> ^d
Sex									
Female	17518	65.8 (0.5)	34.2 (0.5)	<0.0001	<0.0001	4.0 (0.2)	0.0009		
Male	12742	71.3 (0.5)	28.7 (0.5)			3.3 (0.2)	N/A		
Age (years)									
18–39	11589	80.6 (0.5)	19.4 (0.5)	<0.0001	<0.0001	1.4 (0.1)	78.4 (0.7)	7.5 (0.3)	<0.0001
40–49	8249	60.2 (0.7)	39.8 (0.7)			4.8 (0.3)	57.1 (0.9)	13.3 (0.6)	
50–59	7609	50.0 (0.8)	50.0 (0.8)			7.6 (0.4)	47.7 (1.1)	15.6 (0.7)	
60–64	2813	48.5 (1.1)	51.5 (1.1)			7.3 (0.6)	45.5 (1.7)	16.6 (1.2)	
Race/ethnicity									
Latino	5670	82.4 (0.6)	17.6 (0.6)	<0.0001	<0.0001	1.5 (0.2)	80.3 (0.9)	6.9 (0.5)	<0.0001
American Indian/Alaska Native	398	62.5 (3.3)	37.5 (3.3)			4.5 (1.4)	59.9 (4.4)	20.7 (4.1)	
Asian/Pacific Islander	3316	77.9 (0.9)	22.1 (0.9)			3.0 (0.4)	73.9 (1.2)	6.6 (0.7)	
African American	1497	67.6 (1.5)	32.4 (1.5)			3.9 (0.5)	65.0 (2.0)	10.5 (1.2)	
White	18530	57.2 (0.5)	42.8 (0.5)			5.2 (0.2)	54.4 (0.7)	14.7 (0.5)	
Other single/2 or more races	849	74.1 (2.1)	25.9 (2.1)			1.9 (0.5)	71.0 (2.7)	8.3 (1.7)	
Annual household income									
\$0–\$20,000	5217	77.8 (0.8)	22.2 (0.8)	<0.0001	0.0002	2.3 (0.2)	75.2 (1.1)	8.0 (0.6)	<0.0001
\$20,001–\$40,000	5873	74.6 (0.8)	25.4 (0.8)			2.2 (0.2)	70.6 (0.9)	9.5 (0.6)	

Family Medical History of Cancer									
Characteristic	Sample size (unweighted)	Men and women				Women only			
		None, n=18,234	Any, n=12,026	Early onset in first-degree relative (any) n=2,145 ^b	Colorectal cancer n=1,538	None n=10,118 ^c	Breast or ovarian cancer n=2,357 ^c		
		% (SE)	% (SE)	% (SE)	% (SE)	% (SE)	% (SE)	<i>P</i> ^d	<i>P</i> ^d
\$40,001–\$60,000	4820	66.1 (0.9)	33.9 (0.9)	6.6 (0.4)	4.3 (0.3)	63.0 (1.3)	12.1 (0.7)		
>\$60,000	14350	62.5 (0.6)	37.5 (0.6)	6.2 (0.2)	4.8 (0.2)	59.5 (0.8)	12.6 (0.5)		
Education level									
Less than high school	3213	80.7 (1.1)	19.3 (1.1)	5.1 (0.5)	1.3 (0.2)	78.4 (1.3)	5.5 (0.6)	<0.0001	<0.0001
High school graduate	6795	72.3 (0.6)	27.7 (0.6)	5.9 (0.3)	3.4 (0.3)	68.2 (1.0)	10.4 (0.6)		
Some college	8137	65.5 (0.7)	34.5 (0.7)	7.3 (0.4)	4.2 (0.3)	62.5 (0.9)	11.8 (0.6)		
College graduate	12115	62.0 (0.6)	38.0 (0.6)	5.8 (0.3)	4.6 (0.3)	60.6 (0.9)	13.1 (0.5)		
Current health insurance coverage									
Yes	25733	66.1 (0.4)	33.9 (0.4)	6.4 (0.2)	4.1 (0.1)	63.9 (0.5)	11.5 (0.3)	<0.0001	<0.0001
No	4527	79.1 (0.9)	20.9 (0.9)	5.0 (0.4)	1.8 (0.2)	75.3 (1.3)	7.8 (0.5)		
Marital status									
Married	16901	65.5 (0.5)	34.5 (0.5)	6.2 (0.2)	4.1 (0.2)	63.3 (0.7)	11.5 (0.4)	<0.0001	<0.0001
Live with partner	2133	72.7 (1.2)	27.3 (1.2)	6.5 (0.6)	2.5 (0.3)	69.3 (1.8)	11.3 (1.1)		
Divorced/Widowed/ Other	5399	55.9 (1.1)	44.1 (1.1)	8.4 (0.5)	5.9 (0.4)	54.6 (1.3)	14.0 (0.8)		
Single, never married	5827	79.5 (0.8)	20.5 (0.8)	4.7 (0.3)	2.1 (0.2)	77.7 (1.1)	7.2 (0.5)		
General health condition									
Excellent	7287	65.6 (0.8)	34.4 (0.8)	6.1 (0.4)	4.1 (0.3)	62.0 (1.0)	11.6 (0.6)	<0.0001	<0.0001
Very good	10021	66.1 (0.6)	33.9 (0.6)	6.0 (0.3)	4.0 (0.3)	63.3 (0.8)	12.4 (0.6)		
Good	8234	72.9 (0.7)	27.1 (0.7)	5.4 (0.3)	2.9 (0.2)	70.8 (0.9)	9.3 (0.5)		
Fair	3668	70.3 (1.0)	29.7 (1.0)	7.4 (0.5)	3.9 (0.4)	67.9 (1.3)	10.0 (0.7)		
Poor	1050	64.8 (2.0)	35.2 (2.0)	8.0 (1.0)	4.6 (0.7)	60.9 (2.9)	10.1 (1.4)		
Usual source of									

Family Medical History of Cancer									
Characteristic	Sample size (unweighted)	Men and women				Women only			
		None, n=18,234	Any, n=12,026	Early onset in first-degree relative (any) n=2,145 ^b	Colorectal cancer n=1,538	None n=10,118 ^c	Breast or ovarian cancer n=2,357 ^c		
		% (SE)	% (SE)	% (SE)	% (SE)	% (SE)	% (SE)	<i>P</i> ^d	<i>P</i> ^d
health care									
Yes	26743	66.3 (0.4)	33.7 (0.4)	6.4 (0.2)	4.1 (0.1)	64.2 (0.5)	11.4 (0.3)	<0.0001	<0.0001
No	3517	81.1 (0.9)	18.9 (0.9)	4.2 (0.4)	1.5 (0.3)	78.4 (1.2)	6.7 (0.7)		
Having condition that limits basic physical activities									
Yes	4383	59.1 (1.0)	40.9 (1.0)	8.6 (0.5)	5.0 (0.4)	55.7 (1.3)	14.5 (0.9)	<0.0001	<0.0001
No	25877	69.9 (0.4)	30.1 (0.4)	5.7 (0.2)	3.5 (0.1)	67.3 (0.6)	10.3 (0.3)		

^a All percentages presented are weighted.

^b Age at diagnosis was ascertained for FMHs of breast, ovarian, endometrial, colorectal, and prostate cancer. Early onset is considered age < 50 years for the affected relative.

^c This analysis was limited to women only.

^d P-values for site specific FMH of cancer obtained from chi square tests comparing the site specific cancer to persons without a FMH of cancer.

Prevalence^a and adjusted odds ratios of select health behaviors and cancer screening test use among Californians aged 18–64 years by family medical history of cancer, California Health Interview Survey, 2005

TABLE 3

Characteristic	Family medical history (FMH) of cancer						Early onset of colorectal cancer in first-degree relative, <i>n</i> =323 ^b
	None <i>n</i> =18,234	Any <i>n</i> =12,026	<i>p</i> ^c	% (SE), AOR (95% CI)	Colorectal cancer <i>n</i> =1,538	<i>p</i> ^c	Early onset in first-degree relative (any) <i>n</i> =2,145 ^b
	% (SE), AOR (95% CI)	% (SE), AOR (95% CI)			% (SE), AOR (95% CI)		% (SE), AOR (95% CI)
Eat 5 or more servings fruit/vegetables daily							
No	50.5 (0.5)	51.9 (0.7)	0.1206	55.3 (1.6)	0.0057	51.5 (1.7)	54.6 (3.9)
Yes	49.5 (0.5)	48.1 (0.7)		44.7 (1.6)		48.5 (1.7)	45.4 (3.9)
Adjusted OR, 95% CI ^d	ref	0.96 (0.89, 1.04)	0.2847	0.84 (0.73, 0.96)	0.0139	1.00 (0.86, 1.16)	NC
Level of physical activity							
Some/none	67.8 (0.5)	68.2 (0.6)	0.5830	65.8 (1.7)	0.2609	68.8 (1.5)	67.1 (3.8)
Regular physical activity	32.2 (0.5)	31.8 (0.6)		34.2 (1.7)		31.2 (1.5)	32.9 (3.8)
Adjusted OR, 95% CI ^d	ref	0.95 (0.88, 1.03)	0.2148	1.07 (0.92, 1.26)	0.3755	0.97 (0.84, 1.11)	NC
Smoking status							
Current smoker	16.1 (0.4)	16.7 (0.5)	0.3818	15.6 (1.4)	0.7109	18.5 (1.3)	16.5 (2.5)
Not a current smoker	83.9 (0.4)	83.3 (0.5)	0.1059	84.4 (1.4)	0.8565	81.5 (1.3)	83.5 (2.5)
Adjusted OR, 95% CI ^d	ref	0.91 (0.82, 1.02)		0.98 (0.77, 1.24)		0.86 (0.70, 1.05)	NC
Binge drinking on one or more occasions in past month							
Yes	21.1 (0.4)	17.9 (0.5)	<0.0001	15.6 (1.3)	0.0010	17.6 (1.3)	17.3 (3.3)
No	78.9 (0.4)	82.1 (0.5)		84.4 (1.3)		82.4 (1.3)	82.7 (3.3)
Adjusted OR, 95% CI ^d	ref	0.96 (0.88, 1.05)	0.3607	1.01 (0.80, 1.28)	0.9072	1.03 (0.84, 1.26)	NC
Body mass index							
25.0 or higher kg/m ²	54.3 (0.5)	57.4 (0.6)	0.0001	60.6 (1.7)	0.0011	58.4 (1.4)	61.8 (3.9)
							0.0710

Characteristic	Family medical history (FMH) of cancer							
	None <i>n</i> =18,234	Any <i>n</i> =12,026	<i>P</i> ^c	% (SE), AOR (95% CI)	Colorectal cancer <i>n</i> =1,538	<i>P</i> ^c	% (SE), AOR (95% CI)	Early onset in first-degree relative (any) <i>n</i> =2,145 ^b
24.99 kg/m ²	45.7 (0.5)	42.6 (0.6)			39.4 (1.7)			Early onset of colorectal cancer in first-degree relative, <i>n</i> =323 ^b
Adjusted OR, 95% CI ^d	ref	0.91 (0.85, 0.98)	0.0098		0.80 (0.67, 0.94)	0.0068	41.6 (1.4)	% (SE), AOR (95% CI)
Colorectal cancer screening								<i>P</i> ^c
Among adults aged 50–64 years, <i>n</i> =10,310 ^e								
Not up-to-date	55.5 (1.0)	43.8 (1.0)	<0.0001		28.5 (2.2)	<0.0001	43.7 (2.0)	<0.0001
Up-to-date	44.5 (1.0)	56.2 (1.0)			71.5 (2.2)		56.3 (2.0)	34.8 (5.0)
Adjusted OR, 95% CI ^f	ref	1.33 (1.17, 1.51)	<0.0001		2.77 (2.20, 3.49)	<0.0001	1.37 (1.12, 1.66)	65.2 (5.0)
Among adults aged 40–64 years, <i>n</i> =10,594 ^e								NC
Not up-to-date	72.5 (0.6)	NC			42.1 (2.0)	<0.0001	NC	46.7 (4.2)
Up-to-date	27.5 (0.6)				57.9 (2.0)			53.3 (4.2)
Colonoscopy within past 5 years (adults aged 40–64 years), <i>n</i> =10,571								<0.0001
No	85.7 (0.5)	NC			58.6 (2.1)	<0.0001	NC	58.0 (3.8)
Yes	14.3 (0.5)				41.4 (2.1)			42.0 (3.8)
Mammogram screening within past two years (women aged 40–64 years), <i>n</i> =10 865								
No	26.3 (0.9)	19.2 (0.8)	<0.0001		17.0 (1.9)	0.0003	21.2 (1.8)	NC
Yes	73.7 (0.9)	80.8 (0.8)			83.0 (1.9)		78.9 (1.8)	
Adjusted OR, 95% CI ^f	ref	1.24 (1.08, 1.43)	0.0033		1.33 (1.00, 1.78)	0.0536	1.18 (0.95, 1.47)	0.1429

^a All percentages presented are weighted.

^b Age at diagnosis was ascertained for FMHs of breast, ovarian, endometrial, colorectal, and prostate cancer. Early onset is considered age < 50 years for the affected relative.

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^c *P*-values for weighted prevalence estimates obtained from chi square tests comparing the site specific cancer to persons without a FMH of cancer. *P*-values from multivariate logistic regression models compare the site specific cancer to persons without a FMH of cancer (referent group).

^d All health behavior models control for age, sex, race/ethnicity, household income, education, usual health care provider, and marital status. The smoking status model includes health insurance, having a condition that substantially limits one or more basic physical activities, and general health status. The physical activity and healthy weight models include having a condition that substantially limits one or more basic physical activities and general health status. The binge drinking model includes having a condition that substantially limits one or more basic physical activities.

^e Adults aged 50 years and older are considered up-to-date with CRC screening if they have had one of the following tests: fecal occult blood test (FOBT) within the past year, sigmoidoscopy within the past 5 years, or colonoscopy within the past 10 years.

^f All cancer screening models control for age, race/ethnicity, household income, health insurance, and usual health care provider. The CRC screening models include education level.

AOR=adjusted odds ratio

NC=not calculated

Ref=referent group

OR=odds ratio

Prevalence^a and adjusted odds ratios of select health behaviors and cancer screening test use among California women aged 18–64 years by family medical history of breast or ovarian cancer, California Health Interview Survey, 2005

TABLE 4

Family medical history (FMH) of breast or ovarian cancer in women							
Characteristic	No FMH of any cancer <i>n</i> =10,118		Any <i>n</i> =2,357		<i>p</i> ^c	Early onset in first-degree relative, <i>n</i> =829 ^b	
	% (SE), AOR (95% CI)	% (SE), AOR (95% CI)	% (SE), AOR (95% CI)	% (SE), AOR (95% CI)		<i>p</i> ^c	
Eat 5 or more servings fruit/vegetables daily							
No	58.6 (0.7)	57.9 (1.4)	0.6707	59.2 (2.4)		0.8186	
Yes	41.4 (0.7)	42.1 (1.4)		40.8 (2.4)			
Adjusted OR, 95% CI ^d	ref	0.97 (0.84, 1.12)	0.6649	NC			
Level of physical activity							
Some/none	71.3 (0.5)	68.4 (1.3)	0.0211	71.2 (2.0)		0.9682	
Regular physical activity	28.7 (0.5)	31.6 (1.3)		28.8 (2.0)			
Adjusted OR, 95% CI ^d	ref	1.03 (0.91, 1.17)	0.5890	NC			
Smoking status							
Current smoker	11.3 (0.4)	14.0 (1.1)	0.0172	14.3 (1.7)		0.0687	
Not a current smoker	88.7 (0.4)	86.0 (1.1)		85.7 (1.7)			
	ref	0.91 (0.74, 1.12)	0.3498	NC			
Binge drinking on one or more occasions in past month							
Yes	12.6 (0.4)	13.0 (1.0)	0.6343	13.1 (1.9)		0.7614	
No	87.4 (0.4)	87.0 (1.0)		86.9 (1.9)			
Adjusted OR, 95% CI ^d	ref	0.91 (0.76, 1.09)	0.2959	NC			
Body mass index							
25.0 or higher kg/m ²	44.0 (0.7)	48.0 (1.4)		50.8 (2.4)			
24.99 kg/m ²	56.0 (0.7)	52.0 (1.4)	0.0121	49.2 (2.4)		0.0097	
Adjusted OR, 95% CI ^d	ref	0.89 (0.78, 1.03)	0.1070	NC			
Colorectal cancer screening (women aged 50–64 years),							

Family medical history (FMH) of breast or ovarian cancer in women						
Characteristic	No FMH of any cancer <i>n</i> =10,118			Early onset in first-degree relative, <i>n</i> =829 ^b		
	% (SE), AOR (95% CI)	% (SE), AOR (95% CI)	<i>P</i> ^c	% (SE), AOR (95% CI)	<i>P</i> ^c	
<i>n</i> =6,086 ^e						
Not up-to-date	54.5 (1.3)	42.5 (2.1)	<0.0001	NC		
Up-to-date	45.5 (1.3)	57.5 (2.1)				
Adjusted OR, 95% CI ^f	ref	1.38 (1.12, 1.71)	0.0030			
Mammogram screening within past two years (women aged 40–64 years), <i>n</i> =6,940						
No	26.3 (0.9)	14.9 (1.1)	<0.0001	18.5 (2.4)	0.0068	
Yes	73.7 (0.9)	85.1 (1.1)		81.5 (2.4)		
Adjusted OR, 95% CI ^f	ref	1.69 (1.39, 2.04)	<0.0001	NC		
Reason for last mammogram (women aged 30–64 years), <i>n</i> =6,734 ^g						
Part of routine physical exam	85.7 (0.7)	54.0 (1.5)	<0.0001	45.0 (3.0)	<0.0001	
Because of a specific breast problem	6.4 (0.5)	5.1 (0.6)		5.3 (1.2)		
Follow-up to previous breast problem	5.3 (0.5)	7.7 (0.8)		8.0 (1.6)		
Due to family history	2.6 (0.3)	33.2 (1.6)		41.7 (3.1)		
Mammogram screening within past year (women aged 30 – 64 years), <i>n</i> =10,016						
No	63.2 (0.7)	40.6 (1.1)	<0.0001	43.9 (1.8)	<0.0001	
Yes	36.8 (0.7)	59.4 (1.1)		56.1 (1.8)		

^a All percentages presented are weighted.

^b Age at diagnosis was ascertained for FMHs of breast, ovarian, endometrial, colorectal, and prostate cancer. Early onset is considered age < 50 years for the affected relative.

^c *P*-values for weighted prevalence estimates were obtained from chi square tests comparing women with FMH of breast or ovarian cancer to women without a FMH of cancer. *P*-values from multivariate logistic regression models compare women with FMH of breast or ovarian cancer to women without a FMH of cancer (referent group).

^d All health behavior models control for age, race/ethnicity, household income, education, usual health care provider, and marital status. The smoking status model includes health insurance, having a condition that substantially limits one or more basic physical activities, and general health status. The physical activity and healthy weight models include having a condition that substantially limits one or more basic physical activities and general health status. The binge drinking model includes having a condition that substantially limits one or more basic physical activities.

^e Adults aged 50 years and older are considered up-to-date with CRC screening if they have had one of the following tests: fecal occult blood test (FOBT) within the past year, sigmoidoscopy within the past 5 years, or colonoscopy within the past 10 years.

^f All cancer screening models control for age, race/ethnicity, household income, health insurance, and usual health care provider. The CRC screening models include education level.

^g Analysis limited to women who had received a mammogram within the past two years

AOR=adjusted odds ratio

NC=not calculated

Ref=referent group

OR=odds ratio