Research on Cancer Survivors

A research study to help understand life after cancer and what helps survivors thrive!

Cancer Survivor Follow Up Survey

General Cancer Follow-Up Survey
Version: 3
Revised: 8/13/2021

SECTION 1: DEMOGRAPHICS / BACKGROUND INFORMATION

Thank you for continuing to be a part of our research study on cancer survivorship. To begin, we would like to learn a little bit more about your life since you completed your last survey. Please answer every question to the best of your knowledge and as honestly as possible. There are no right or wrong answers.

1.1 Which of the following phrases best describes your **current** employment status?

- ❍ Employed full time (including self-employed)
- ❍ Employed part-time (including self-employed)
- ❍ Homemaker
- ❍ Unemployed
- ❍ Retired
- ❍ On Disability
- ❍ Other: (please specify): _____

→ Approximately how many hours per week do you work on average?

_____

1.2 What is or was your usual occupation?

- ❍ Professional/Technical (e.g. accountant, engineer, doctor, nurse, social worker, teacher, draftsman, actress, computer programmer)
- ❍ Manager/Administrator (e.g. treasurer, buyer, government official, sales)
- ❍ Sales Worker (e.g. real estate agent, sales representative)
- ❍ Clerical Worker (e.g. bank teller, file clerk, dispatcher, secretary)
- ❍ Service Worker (e.g. janitor, waitress, flight attendant, hairdresser, maid)
- ❍ Craftsperson (e.g. baker, floor layer, foreman, machinist, mechanic, tailor)
- ❍ Operative (e.g. assembler, machine operator, bus or taxicab driver)
- ❍ Farmer/Farm Laborer
- ❍ Other: (please specify): _____

1.3 What kind of health insurance do you **currently** have? (Please select all that apply)

- ❍ Medicare
- ❍ Medicaid
- ❍ Private insurance (i.e. Blue Cross, Molina, HAP) through my or my partner's employer
- ❍ Private insurance (i.e. Blue Cross, Molina, HAP) that I purchased on my own (not through an employer)
- ❍ VA
- ❍ I do not have insurance
- ❍ Other: (please specify): _____

SECTION 2: HEALTH BEHAVIORS – SEDENTARY TIME

The next section asks about your health behaviors.

2.1 On average, in the **past 12 months**, how many hours each day did you spend sitting at home?

❍ Less than 1 ❍ 1-2 ❍ 3-4 ❍ 5 or more

2.2 On average, in the **past 12 months**, how many hours each day did you spend sitting at work?

❍ Less than 1 ❍ 1-2 ❍ 3-4 ❍ 5-6
❍ 7-8 ❍ More than 8 ❍ Not applicable

2.3 On average, in the **past 12 months**, how many hours each day did you spend sleeping or laying down?

❍ Less than 5 ❍ 5-6 ❍ 7-8 ❍ 9-10 ❍ More than 10

SECTION 3: HEALTH BEHAVIORS – PHYSICAL ACTIVITY

The next section asks about your physical activity.

3.1 Physical activity can include any activity that increases your heart rate, such as walking, jogging, yard work, shoveling snow, etc. In the **past 4 weeks**, did you participate in any physical activity to improve or maintain your physical fitness?

❍ Yes → **Go To Question 3.2** ❍ No → **Go To Section 4**

3.2 ***Vigorous*** activities are those that cause large increases in breathing or heart rate, during which you can only say a few words without stopping to catch your breath (such as aerobic or fast dancing, jumping rope, race walking, jogging, or running, swimming laps, tennis, or heavy yard work). In the **past 4 weeks**, did you participate in regular vigorous exercise, at least once a week?

❍ Yes ❍ No → **Go To Question 3.5**

3.3 In the **past 4 weeks**, how many times each week did you participate in ***vigorous*** activities on average?

❍ Once ❍ 2-4 times ❍ 5-6 times ❍ 7 times or more

3.4 When you did ***vigorous*** activities in **the past 4 weeks**, for how many minutes on average did you do them each time?

❍ Less than 10 minutes
❍ 10-19 minutes
❍ 20-29 minutes
❍ 30-44 minutes
❍ 45-59 minutes
❍ 60 minutes or more

3.5 ***Moderate*** activities are those that cause small increases in breathing or heart rate (such as walking briskly, biking on level ground or with few hills, playing golf, ballroom or line dancing, general gardening, or using a manual wheelchair). **In the past 4 weeks** did you participate in any moderate activities at least once a week?

❍ Yes ❍ No → **Go To Section 4**

3.6 In the **past 4 weeks**, how many times each week did you do ***moderate*** activities on average?

❍ Once ❍ 2-4 times ❍ 5-6 times ❍ 7 times or more

3.7 When you did ***moderate*** activities in the **past 4 weeks**, for how many minutes on average did you do them each time?

❍ Less than 10 minutes
❍ 10-19 minutes
❍ 20-29 minutes
❍ 30-44 minutes
❍ 45-59 minutes
❍ 60 minutes or more

SECTION 4: HEALTH BEHAVIORS – DIET

4.1 In the **past 4 weeks**, how many servings of fruit (such as a medium apple or banana or 1 cup of grapes or berries) did you eat per day? **Do not count juices**.

- ❍ None, or less than 1 per day
- ❍ 1 per day
- ❍ 2 per day
- ❍ 3 per day
- ❍ 4 per day
- ❍ 5 or more per day

4.2 In the **past 4 weeks**, how many servings of vegetables (like green salad, green beans, tomatoes, carrots, onions, or broccoli) did you eat per day? **Do not count fried potatoes**. (A serving is one cup of vegetables such as broccoli or carrots or cooked greens, or 2 cups of raw leafy greens such as lettuce or spinach.)

- ❍ None, or less than 1 per day
- ❍ 1 per day
- ❍ 2 per day
- ❍ 3 per day
- ❍ 4 per day
- ❍ 5 or more per day

In the past 4 weeks, how often did you …	Never, or less than once per week	1-3 times per week	4-6 times per week	Once per day	More than once per day
4.3 eat processed meat, such as ham, bologna, salami, hot dogs, bacon or sausage?	❍	❍	❍	❍	❍
4.4 eat other red meat, such as steak, hamburger, pork or lamb, alone or in other dishes such as sandwiches, pasta or pizza?	❍	❍	❍	❍	❍
4.5 have a serving of regular soda or pop that contains sugar? (A serving is the same as a 12-oz can of soda). **Do not include diet soda**.	❍	❍	❍	❍	❍
4.6 eat fast food such as McDonald's, KFC or Taco Bell?	❍	❍	❍	❍	❍
4.7 eat sweets or desserts such a cookies, cake, pie or ice cream?	❍	❍	❍	❍	❍
In the past 4 weeks…	**None, or less than 1**	**1-3**	**4-6**	**7-9**	**10 or more**
4.8 how many glasses of water did you drink each day? (A glass is equal to 8 ounces)	❍	❍	❍	❍	❍

SECTION 5: HEALTH BEHAVIORS – TOBACCO

The next items ask about cigarette smoking. Please think about cigarette smoke only, and do not include the smoke from a pipe or cigars.

5.1 Do you **currently** smoke cigarettes on a regular basis (at least one cigarette a day for the past month)?

❍ Yes → **Go To Question 5.4** ❍ No → **Go To Question 5.2**

5.2 Did you quit smoking cigarettes in the **last 12 months**?

❍ Yes → **Go To Question 5.3** ❍ No → **Go To Question 5.5**

5.3 When did you quit smoking cigarettes?

Month _____ Year _____

5.4 **In the last 12 months,** how many cigarettes did you smoke, on average, per day **or** per week? (Note: There are 20 cigarettes in a pack. If you smoke 1 pack per day you would enter 20.)

_____ Cigarettes per day **OR** _____ Cigarettes per week

5.5 Do you live in the same household with someone who smokes cigarettes regularly (at least one cigarette a day for a month or more) while in your presence?

❍ Yes ❍ No

5.6 Do you **currently** vape or smoke e-cigarettes?

❍ Yes ❍ No

SECTION 6: HEALTH BEHAVIORS – ALCOHOL USE

These next items will ask about your recent alcohol consumption over the **past 4 weeks**.

6.1. In the **past 4 weeks**, have you consumed alcoholic beverages such as beer, wine, or liquor?

❍ Yes ⟶ **Go To Question 6.2** ❍ No ⟶ **Go To Next Section**

6.2. In the **past 4 weeks**, how many of each type of alcoholic beverage did you consume per week, on average? If less than 1 per week, enter 0 (zero).

Number per week

_____ 5 oz. glasses of wine

_____ 12 oz. cans or bottles of beer

_____ 1.5 oz. shots of liquor (such as whiskey, gin, vodka; straight or mixed)

_____ 8 oz. malt liquor

6.3. Is this more than, less than, or typical of your average alcohol consumption?

❍ More than usual
❍ Less than usual
❍ Typical alcohol consumption

SECTION S: SLEEP SUPPLEMENT

Next, you will be asked a series of questions related to your usual sleep habits during **the past two weeks**. Your answers should indicate the most accurate reply for the majority of days and nights.

S1. During the past two weeks,	**No**	**Yes**	**If Yes:**	**Mild**	**Moderate**	**Severe**	**Very Severe**
a. Have you had difficulty falling asleep?	❍	❍	How severe is this problem?	❍	❍	❍	❍
b. Have you had difficulty staying asleep?	❍	❍	How severe is this problem?	❍	❍	❍	❍
c. Have you had a problem waking up too early?	❍	❍	How severe is this problem?	❍	❍	❍	❍

S2. If Yes to Sleep Health a, b or c above; Did these problems occur at least 3 times per week?

❍ Yes ❍ No

S3. During the past two weeks,	**Not at all**	**A little**	**Some -what**	**Much**	**Very much**
a. To what extent have you considered your sleep problem to interfere with your daily functioning (such as daytime fatigue, your mood or your memory)?	❍	❍	❍	❍	❍
b. How noticeable to others do you think your sleeping problem is in terms of impairing the quality of your life?	❍	❍	❍	❍	❍
c. How worried or distressed are you about your current sleep problem?	❍	❍	❍	❍	❍

S4. How satisfied or dissatisfied have you been with your sleep patterns?

❍ Very Satisfied ❍ Mildly Satisfied ❍ Very Dissatisfied
❍ Satisfied ❍ Dissatisfied

The next set of questions will ask about your sleep over **the past week only**. Your answers should indicate the most accurate reply for the majority of days and nights in the past week.

S5. During the past week, what time did you usually go to bed at night? (that is, turn off the lights and try to go to sleep for the night)?

Time: _____ am/ pm

S6. During the past week, how long (in minutes) did it usually take you to fall asleep each night?

Minutes to fall asleep: _____

S7. During the past week, when have you usually gotten up (out of bed) in the morning? (That is, get out of bed for the day?)

Time: _____ am/ pm

S8. During the past week, how many hours of actual sleep did you get at night? (This may be different than the number of hours you spend in bed).

Hours of sleep each night: _____

S9. During the past week, how often did you have trouble sleeping because you…	**Not at all**	**Once a week**	**Twice a week**	**3 times or more a week**	**Don't know**
a. Could not get to sleep within 30 minutes	❍	❍	❍	❍	❍
b. Woke up in the middle of the night or early morning	❍	❍	❍	❍	❍
c. Had to use the bathroom	❍	❍	❍	❍	❍
d. Could not breathe comfortably	❍	❍	❍	❍	❍
e. Coughed or sneezed loudly	❍	❍	❍	❍	❍
f. Felt too cold	❍	❍	❍	❍	❍
g. Felt too hot	❍	❍	❍	❍	❍
h. Had bad dreams	❍	❍	❍	❍	❍
i. Heard noises	❍	❍	❍	❍	❍
j. Have pets	❍	❍	❍	❍	❍
k. Other reason(s); Please describe: _____	❍	❍	❍	❍	❍
l. **During the past week**, how often did you take medicine (prescribed or "over the counter") to help you sleep?	❍	❍	❍	❍	❍
m. **During the past week,** how often did you have trouble staying awake while eating meals, or engaging in social activity?	❍	❍	❍	❍	❍

The next set of questions will ask about your sleep over **the past week only**. Your answers should indicate the most accurate reply for <u>the majority</u> of days and nights in the past week.

S10. During the past week, how much of a problem has it been for you to keep up enough enthusiasm to get things done?

❍ No Problem ❍ Somewhat ❍ Don't know
❍ Very slight ❍ Very big

S11. During the past week, how would you rate your sleep quality overall?

❍ Very good ❍ Fairly bad
❍ Fairly good ❍ Very bad

S12. Does anyone sleep in the same room as you?

❍ Yes ❍ No

S13. Does anyone sleep in the same bed as you?

❍ Yes ❍ No

Next, we would like to know how likely you are to doze off or fall asleep if you were in the following situations. This is in contrast to feeling just tired. Even if you did not do some of these things recently, try to think how they would have affected you.

S14. During the past week, how likely were you to have dozed off while you were…	**Would never doze**	**Slight chance of dozing**	**Moderate chance of dozing**	**High chance of dozing**
a. Sitting and reading	❍	❍	❍	❍
b. Watching TV	❍	❍	❍	❍
c. Sitting, inactive in a public place (e.g., a theater or a meeting)	❍	❍	❍	❍
d. As a passenger in a car for an hour without a break	❍	❍	❍	❍
e. Lying down to rest in the afternoon when circumstances permit	❍	❍	❍	❍
f. Sitting and talking to someone	❍	❍	❍	❍
g. Sitting quietly after a lunch without alcohol	❍	❍	❍	❍
h. In a car driving, while stopped for a few minutes in traffic	❍	❍	❍	❍

SECTION 7: FAMILY HISTORY OF CANCER

Next, we would like to know about **any cancer** that has been diagnosed among your biological family.

7.1 Have any of the following biological relatives been diagnosed with cancer: parents, grandparents, full brothers or sisters (with whom you share the same biological mother **and** biological father), and/or children?

Please do not include adoptive or step-parents, adopted, half, or step-brothers or sisters, or adopted or step-children for this item.

Please include both living and deceased relatives.

❍ Yes → **Go To Question 7.2**

❍ No → **Go To Section 8**

❍ Don't know → **Go To Section 8**

7.2 Please provide information in the table below about all of your biological relatives' cancers, including **whether they are still living**, **cancer type**, **age at diagnosis**, and **date of diagnosis**.

Relationship to you	Is this family member still living?		Type of cancer(s)	Age when first diagnosed with any cancer?	Approximate date of diagnosis
	Yes	No			
_____	❍	❍	_____	_____	_____
_____	❍	❍	_____	_____	_____
_____	❍	❍	_____	_____	_____
_____	❍	❍	_____	_____	_____
_____	❍	❍	_____	_____	_____
_____	❍	❍	_____	_____	_____
_____	❍	❍	_____	_____	_____
_____	❍	❍	_____	_____	_____
_____	❍	❍	_____	_____	_____
_____	❍	❍	_____	_____	_____
_____	❍	❍	_____	_____	_____
_____	❍	❍	_____	_____	_____

SECTION 8: MEDICAL HISTORY

The next items will ask about your weight and medical history.

8.1 What is your **current** weight? _____ pounds

8.2 Has a doctor **ever** told you that you have any of the following medical conditions? For each condition, please **check Yes / No / Unsure**, give your approximate **age at diagnosis**, and whether you are **currently being treated**.

Medical Condition	Ever Diagnosed? Yes	No	Unsure	Approximate age of diagnosis	Currently Being Treated? Yes	No
1. Arthritis	❍	❍	❍	_____	❍	❍
↳ What kind? ❍ Rheumatoid ❍ Osteoarthritis ❍ Unsure						
2. Emphysema	❍	❍	❍	_____	❍	❍
3. COPD (chronic obstructive pulmonary disease)	❍	❍	❍	_____	❍	❍
4. Depression	❍	❍	❍	_____	❍	❍
5. Diabetes	❍	❍	❍	_____	❍	❍
↳ What kind? ❍ Type I ❍ Type II ❍ Unsure						
6. Fracture (broken bone), over age 50	❍	❍	❍	_____	❍	❍
↳ Part of body? _____						
7. Heart Problems	❍	❍	❍	_____	❍	❍
↳ What kind? ❍ Heart Attack ❍ Congestive Heart Failure ❍ Afib (Atrial fibrillation) ❍ Coronary artery disease ❍ Other ❍ Unsure						
8. Hepatitis (any type)	❍	❍	❍	_____	❍	❍
9. High cholesterol	❍	❍	❍	_____	❍	❍
10. Hypertension (high blood pressure)	❍	❍	❍	_____	❍	❍
11. Stroke	❍	❍	❍	_____	❍	❍
12. Thyroid problem	❍	❍	❍	_____	❍	❍
13. Any other medical condition *not previously listed*	❍	❍	❍	_____	❍	❍
↳ Name of ***other*** medical condition(s)? _____						

8.3 Have you **ever** been diagnosed with any **other** cancer?

❍No ❍ Yes →

Type of Cancer	Age at Diagnosis

It would be helpful to have a list of all of your current prescription medications, or the medications themselves, before you begin this next question.

8.4 Are you **currently** taking any ***prescription*** medications?

❍ Yes ⟶ **Complete table below** ❍ No ⟶ **Go To Question 8.5**

Please provide all ***prescription*** medications you are **currently** taking and the duration for which you have taken them.

Medication Name	For how long have you taken this medication?			
	Less than 6 Months	6 Months to Less than 1 Year	1 to 3 Years	More than 3 Years
	❍	❍	❍	❍
	❍	❍	❍	❍
	❍	❍	❍	❍
	❍	❍	❍	❍
	❍	❍	❍	❍
	❍	❍	❍	❍
	❍	❍	❍	❍
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	❍	❍	❍	❍
	❍	❍	❍	❍
	❍	❍	❍	❍
	❍	❍	❍	❍
	❍	❍	❍	❍
	❍	❍	❍	❍

FOR WOMEN: Hormone therapy consists of hormones that are taken around the time of or after menopause.

FOR MEN: Hormone therapy consists of hormones that are taken for symptoms of low testosterone.

For this section, please only include hormones NOT related to cancer treatment. (You will be asked about hormone use related to cancer treatment in a later section.)

8.5 Have you **ever** taken Hormone Therapy (HT)?

❍ Yes ⟶ **Go To Question 8.6** ❍ No ⟶ **Go To Section 9**

8.6 For how long did you take hormone therapy?

❍ Less than 6 months
❍ 6 months to less than 1 year
❍ 1 to 3 years
❍ 3 to 5 years
❍ More than 5 years

8.7 What is the name of the hormone you took or are currently taking? (Select all that apply)

❍ Testosterone
(Andro Gel, Fortests, Testim, Depo-T, Aveed, Testopel, Androderm, Testoderm, Android, etc...)
❍ Estrogen
(Climara, Estradiol, Estraderm, Estrasorb, Estratab, FemRing, Menostar, Premarin, Vagifem, etc...)
❍ Combination Estrogen and Progestin
(Climara Pro, CombiPatch, Prempro, Activella, Prefest, Femhrt, etc...)
❍ Other
please specify: _____

8.8 What form of the hormone did/ do you use? (Select all that apply)

❍ Oral Pill
❍ Cream
❍ Suppository
❍ Skin Patch
❍ Shot
❍ Other, please specify: _____

SECTION 9: VITAMINS AND PAIN MEDICATIONS

The next items ask about your use of vitamins, supplements and non-prescription pain medications.

9.1 Do you **currently** take a daily multi-vitamin?

❍ Yes ❍ No

9.2 Do you **currently** take any other vitamin or supplement daily?

❍ Yes → **Go To Question 9.3** ❍ No → **Go To Question 9.4**

9.3 What other vitamin or supplement do you **currently** take **daily**? (Please select all that apply)

Vitamin or supplement	Please check here if you take this daily
Stress-tabs or B-Complex	❍
Vitamin A	❍
Vitamin C	❍
Vitamin D	❍
Vitamin E	❍
Calcium	❍
Fiber products (such as Metamucil, Citrucel, FiberCon, or Fiberall)	❍

9.4 In the **past year**, have you taken any of the following **at least once a week for at least one month**? [Please check all that apply and indicate the number of months and days per week for each.]

Medication	Please check if you have taken this medication at least once a week for at least one month	How many days per week? 3 days per week or less	How many days per week? 4 days per week or more	For how many months in the past year have you taken this medication?
Acetaminophen (such as Tylenol or Aspirin-free Excedrin)	❍	❍	❍	_____
Aspirin (such as Anacin, Bufferin, Alka-Seltzer, Bayer, or Excedrin, or baby/ low-dose aspirin)				
Full Strength Aspirin (325 mg)	❍	❍	❍	_____
Baby Aspirin (81 mg)	❍	❍	❍	_____
Ibuprofen (such as Advil, Motrin, Nuprin, or Mediprin)	❍	❍	❍	_____
Naproxen (such as Aleve, Naprosyn, Anaprox, or Naprelan)	❍	❍	❍	_____
Other over-the-counter pain relievers	❍	❍	❍	_____

SECTION 10: CANCER TREATMENT

The next few items ask about treatment for your cancer.

10.1 **Since completing your last survey**, have you had surgery for your cancer?

❍ Yes → **Go To Question 10.2** ❍ No → **Go To Question 10.3**

10.2 What month and year was your surgery?

Month _____ Year _____

10.3 **Since completing your last survey**, have you had radiation for your cancer?

❍ Yes → **Go To Question 10.4** ❍ No → **Go To Question 10.6**

10.4 What month and year did your radiation therapy **begin**?

Month _____ Year _____

10.5 What month and year did your radiation therapy **end**?

Month _____ Year _____

-OR- Check **here** ❍ if you are **currently** undergoing radiation therapy

10.6 **Since completing your last survey**, have you received hormone therapy (in any form) to treat your cancer?

❍ Yes → **Go To Question 10.7** ❍ No → **Go To Question 10.9**

10.7 What month and year did your hormone therapy **begin**?

Month _____ Year _____

10.8 What month and year did your hormone therapy **end**?

Month _____ Year _____

-OR- Check **here** ❍ if you are **currently** undergoing hormone therapy

10.9 **Since completing your last survey**, have you received immunotherapy to treat your cancer?

❍ Yes → **Go To Question 10.10** ❍ No → **Go To Question 10.12**

10.10 What month and year did your immunotherapy **begin**?

Month _____ Year _____

10.11 What month and year did your immunotherapy **end**?

Month _____ Year _____

-OR- Check **here** ❍ if you are **currently** undergoing immunotherapy

10.12 **Since completing your last survey**, have you had chemotherapy for your cancer (oral or IV)?

❍ Yes → **Go To Question 10.13** ❍ No → **Go To Question 10.16**

10.13 What month and year did your chemotherapy **begin**?

Month _____ Year _____

10.14 What month and year did your chemotherapy **end**?

Month _____ Year _____

-OR- Check **here** ❍ if you are **currently** undergoing chemotherapy

10.15a Since receiving chemotherapy have you experienced numbness, pain or tingling in your hands or feet?

❍ Yes, currently
❍ Yes, formerly
→ **Go To Question 10.15b** ❍ No, never → **Go To Question 10.15e**

10.15b Please choose the statement that best describes the numbness, pain or tingling in your hands or feet:

❍ Mild and (does not / did not) interfere with your activities of daily living.
❍ Moderate and (does not / did not) interfere with your activities of daily living.
❍ Moderate to severe and (interferes / interfered) with your activities of daily living.
❍ Severe and completely (prevents / prevented) you from doing most activities of daily living.

10.15c Had you experienced these symptoms prior to your chemotherapy treatment? (Select all that apply)

❍ Yes, numbness
❍ Yes, pain
❍ Yes, tingling
→ **Go To Question 10.15d** ❍ No → **Go To Question 10.15e**

10.15d Has the numbness, pain, or tingling in your hands or feet worsened with chemotherapy treatment?

❍ Yes ❍ No

10.15e Since receiving chemotherapy have you ever experienced weakness in your arms or legs?

❍ Yes, currently
❍ Yes, formerly
→ **Go To Question 10.15f** ❍ No, never → **Go To Question 10.15i**

10.15f Please choose the statement that best describes the weakness in your arms or legs:

❍ Mild and (does not / did not) interfere with your activities of daily living.
❍ Moderate and (does not / did not) interfere with your activities of daily living.
❍ Moderate to severe and (interferes / interfered) with your activities of daily living.
❍ Severe and completely (prevents / prevented) you from doing most activities of daily living.

10.15g Had you experienced these symptoms prior to your chemotherapy treatment?

❍ Yes → **Go To Question 10.15h** ❍ No → **Go To Question 10.15i**

10.15h Has the weakness in your arms or legs worsened with chemotherapy treatment?

❍ Yes ❍ No

10.15i Which (if any) activities have been interfered with as a result of any of these symptoms? (select all that apply)

- ❍ Sleeping
- ❍ Working
- ❍ Putting on jewelry
- ❍ Using utensils (fork, spoon, knife)
- ❍ Opening doors
- ❍ Writing
- ❍ Putting in or removing contact lenses
- ❍ Typing on a keyboard
- ❍ Driving
- ❍ Walking
- ❍ Buttoning clothes or fastening buckles
- ❍ Tying shoes
- ❍ Using a telephone
- ❍ Climbing stairs
- ❍ Sewing
- ❍ Operating a remote control
- ❍ Knitting
- ❍ Performing other activities of importance to me (please specify) _____
- ❍ **None of the above** / not applicable

10.16 At which institution(s) did you receive your **new** cancer treatment or surgery? (Select all that apply.)

- ❍ Karmanos Cancer Center
- ❍ Beaumont / Oakwood
- ❍ Henry Ford Health System
- ❍ DMC (Sinai, Harper, Detroit Receiving)
- ❍ McLaren Health System
- ❍ St. John / Providence
- ❍ St. Joseph Mercy
- ❍ Other (specify) _____

10.17 Have you completed treatment (surgery, radiation, chemotherapy, etc.) for your initial cancer diagnosis? Please **do not** count long-term hormone therapy (such as Tamoxifen or aromatase inhibitors) that some survivors take for several years after completing other cancer treatment.

- ❍ Yes, I have completed treatment → **Go To Question 10.18**
- ❍ No, I am still undergoing treatment → **Go To Section 11**
- ❍ No, I have not received any treatment → **Go To Section 11**

10.18 What month and year did you complete treatment?

Month _____ Year _____

SECTION 11: CANCER SCREENING

11.1 In the **last 12 months**, have you had any of the following **cancer screening** tests? [Please check all that apply.]

Type of screening test:	Have you had this type of test in the last 12 months?		
	Yes	No	Don't know
LUNG CANCER SCREENING TEST:			
Screening CT scan of the lungs	❍	❍	❍
COLORECTAL CANCER SCREENING TESTS:			
Colonoscopy (entire colon) or sigmoidoscopy (lower colon only)	❍	❍	❍
Fecal occult blood test (FOBT – looks for blood in feces)	❍	❍	❍
BREAST CANCER SCREENING TESTS: (FOR WOMEN)			
Mammogram	❍	❍	❍
Clinical breast exam (a breast exam performed by a health care provider)	❍	❍	❍
CERVICAL CANCER SCREENING TESTS: (FOR WOMEN)			
Pap smear (a swab of the cervix)	❍	❍	❍
PROSTATE CANCER SCREENING TESTS: (FOR MEN)			
Prostate Specific Antigen test (PSA – blood test)	❍	❍	❍
Digital Rectal Exam (DRE – doctor checks prostate by inserting a finger into the rectum)	❍	❍	❍

SECTION 12: QUALITY OF LIFE

The following questions ask about your physical, social, emotional and functional well-being that other cancer patients and survivors have said are important.

For each item, please select the one response [per row] that best reflects your experience in the past 7 days.

Over the past 7 days:	Not at all	A little bit	Some-what	Quite a bit	Very much
PHYSICAL WELL-BEING					
I have a lack of energy	❍	❍	❍	❍	❍
I have nausea	❍	❍	❍	❍	❍
Because of my physical condition, I have trouble meeting the needs of my family	❍	❍	❍	❍	❍
I have pain	❍	❍	❍	❍	❍
I am bothered by side effects of treatment	❍	❍	❍	❍	❍
I feel ill	❍	❍	❍	❍	❍
I am forced to spend time in bed	❍	❍	❍	❍	❍
SOCIAL/FAMILY WELL-BEING					
I feel close to my friends	❍	❍	❍	❍	❍
I get emotional support from my family	❍	❍	❍	❍	❍
I get support from my friends	❍	❍	❍	❍	❍
My family has accepted my illness	❍	❍	❍	❍	❍
I am satisfied with family communication about my illness	❍	❍	❍	❍	❍
I feel close to my partner (or the person who is my main support)	❍	❍	❍	❍	❍
Regardless of your current level of sexual activity, please answer the following question. If you prefer not to answer it, please mark this box ☐ and go to the next question.					
I am satisfied with my sex life	❍	❍	❍	❍	❍
EMOTIONAL WELL-BEING					
I feel sad	❍	❍	❍	❍	❍
I am satisfied with how I am coping with my illness	❍	❍	❍	❍	❍
I am losing hope in the fight against my illness	❍	❍	❍	❍	❍
I feel nervous	❍	❍	❍	❍	❍
I worry about dying	❍	❍	❍	❍	❍
I worry that my condition will get worse	❍	❍	❍	❍	❍
FUNCTIONAL WELL-BEING					
I am able to work (include work at home)	❍	❍	❍	❍	❍
My work (include work at home) is fulfilling	❍	❍	❍	❍	❍
I am able to enjoy life	❍	❍	❍	❍	❍
I have accepted my illness	❍	❍	❍	❍	❍
I am sleeping well	❍	❍	❍	❍	❍
I am enjoying the things I usually do for fun	❍	❍	❍	❍	❍
I am content with the quality of my life right now	❍	❍	❍	❍	❍

SECTION 13: COGNITIVE FUNCTION

Below is a list of statements that other people with your condition have said are important.

For each item, please select the one response [per row] that best reflects your experience in the past 7 days.

Over the past 7 days:	Never	About once a week	Two to three times a week	Nearly every day	Several times a day
I have had trouble forming thoughts	❍	❍	❍	❍	❍
My thinking has been slow	❍	❍	❍	❍	❍
I have had trouble concentrating	❍	❍	❍	❍	❍
I have had trouble finding my way to a familiar place	❍	❍	❍	❍	❍
I have had trouble remembering where I put things, like my keys or my wallet	❍	❍	❍	❍	❍
I have had trouble remembering new information, like phone numbers or simple instructions	❍	❍	❍	❍	❍
I have had trouble recalling the name of an object while talking to someone	❍	❍	❍	❍	❍
I have had trouble finding the right word(s) to express myself	❍	❍	❍	❍	❍
I have used the wrong word when I referred to an object	❍	❍	❍	❍	❍
I have had trouble saying what I mean in conversations with others	❍	❍	❍	❍	❍
I have walked into a room and forgotten what I meant to get or do there	❍	❍	❍	❍	❍
I have had to work really hard to pay attention or I would make a mistake	❍	❍	❍	❍	❍
I have forgotten names of people soon after being introduced	❍	❍	❍	❍	❍
My reactions in everyday situations have been slow	❍	❍	❍	❍	❍
I have had to work harder than usual to keep track of what I was doing	❍	❍	❍	❍	❍
My thinking has been slower than usual	❍	❍	❍	❍	❍
I have had to work harder than usual to express myself clearly	❍	❍	❍	❍	❍
I have had to use written lists more often than usual so I would not forget things	❍	❍	❍	❍	❍
I have trouble keeping track of what I am doing if I am interrupted	❍	❍	❍	❍	❍
I have trouble shifting back and forth between different activities that require thinking	❍	❍	❍	❍	❍

SECTION 14: EMOTIONAL HEALTH

The next several questions ask about your mental and emotional health. For each item, please select the one response [per row] that best reflects your experience **in the past 7 days**.

Over the past 7 days:	Never	Rarely	Some-times	Often	Always
I felt fearful	❍	❍	❍	❍	❍
I found it hard to focus on anything other than my anxiety	❍	❍	❍	❍	❍
My worries overwhelmed me	❍	❍	❍	❍	❍
I felt uneasy	❍	❍	❍	❍	❍
I felt worthless	❍	❍	❍	❍	❍
I felt helpless	❍	❍	❍	❍	❍
I felt depressed	❍	❍	❍	❍	❍
I felt hopeless	❍	❍	❍	❍	❍

SECTION 15: FINANCIAL CONCERNS

The next several questions relate to your household income and financial concerns.

15.1 How would you describe your **current** financial situation?

- ❍ Not enough to get by
- ❍ Barely enough to get by
- ❍ Have enough to get by, but no extras
- ❍ Have more than enough to get by

15.2 What was your household income **last year**, before taxes?

- ❍ Less than $10,000
- ❍ $10,000-$19,999
- ❍ $20,000-$39,999
- ❍ $40,000-$59,999
- ❍ $60,000-$79,999
- ❍ $80,000 or more

15.3 Has your income changed in the **last 12 months**?

- ❍ Yes, it has increased
- ❍ Yes, it has decreased
- ❍ No

15.4 How many people **currently** live in your household (please include yourself)? _____

15.5 Have you moved in the **last 12 months**?

❍ Yes → **Go To Question 15.6** ❍ No → **Go To Question 15.7**

15.6 How long have you lived at your current address?

- ❍ Less than 6 months
- ❍ 6 months - 1 year

15.7 Please select one response per item as it applies to you over the **past 7 days:**

Over the past 7 days:	Not at all	A little bit	Some-what	Quite a bit	Very much
I feel financially stressed.	❍	❍	❍	❍	❍
I am satisfied with my current financial situation.	❍	❍	❍	❍	❍
I worry about the financial problems I will have in the future as a result of my illness or treatment.	❍	❍	❍	❍	❍
I am frustrated that I cannot work or contribute as much as I usually do.	❍	❍	❍	❍	❍
My cancer or treatment has reduced my satisfaction with my present financial situation.	❍	❍	❍	❍	❍
I feel in control of my financial situation.	❍	❍	❍	❍	❍
I am able to meet my monthly expenses.	❍	❍	❍	❍	❍
I know that I have enough money in savings, retirement, or assets to cover the costs of my treatment.	❍	❍	❍	❍	❍
I am concerned about keeping my job and income, including working at home.	❍	❍	❍	❍	❍
I feel I have no choice about the amount of money I spend on care.	❍	❍	❍	❍	❍
My out-of-pocket medical expenses are more than I thought they would be.	❍	❍	❍	❍	❍

15.8 Was there a time in the **last 12 months** when you needed to see a doctor but could not because of the cost?

❍ Yes ❍ No

If you have not received any treatment for your cancer since completing your last survey, please skip to Question 15.14

15.9 In the **last 12 months**, in order to pay bills related to your recent cancer treatment, have you had to do any of the following? (Select all that apply.)

❍ Refinancing / second mortgage on your home
❍ Sell your home
❍ Sell stock or other investments
❍ Withdraw money from retirement accounts
❍ Withdraw money from savings accounts
❍ Other (Please specify) _____
❍ None of the above

15.10 In the **last 12 months**, have you gone into debt or borrowed money to pay bills related to your recent cancer treatment?

❍ Yes → **Go To Question 15.11** ❍ No → **Go To Question 15.12**

15.11 What kind(s) of debt did you experience in the **last 12 months** due to your recent cancer treatment? (Select all that apply.)

❍ Debt to hospital or medical providers ❍ Credit card debt
❍ Borrowed money from family or friends ❍ Borrowed money against your home
❍ Took out a bank loan ❍ Borrowed money against a retirement account
❍ Other (please specify) _____

15.12 In the **last 12 months**, have you turned down treatments for your cancer (chemotherapy, radiation, pain medications, anti-nausea medications, anti-diarrhea medications, or other recommended cancer treatments) because you were concerned about the costs?

❍ Yes ❍ No

15.13 In the **last 12 months**, have you skipped doses of prescribed medication to save money?

❍ Yes ❍ No

15.14 Are you **currently** working (either full or part time) and/ or were you working in the **last 12 months**?

❍ Yes → **Go To Question 15.15** ❍ No → **Go To Section 16**

15.15 In the **last 12 months**, have you had to do any the following? (Please answer yes or no for each option):

	Yes	No
Change your work schedule	❍	❍
Take extended paid time off from work	❍	❍
Take unpaid time off from work	❍	❍
Change the number of hours you work each week	❍	❍
Change your job duties	❍	❍
Change employment status (for example, leave your job or get a new job)	❍	❍

15.16 In the **last 12 months**, how much paid sick time have you used?

- ❍ Less than 1 week
- ❍ 1 week to 1 month
- ❍ 1-3 months
- ❍ 3-6 months
- ❍ 6 months or more
- ❍ None

15.17 In the **last 12 months**, how much paid vacation time have you used?

- ❍ Less than 1 week
- ❍ 1 week to 1 month
- ❍ 1-3 months
- ❍ 3-6 months
- ❍ 6 months or more
- ❍ None

15.18 In the **last 12 months**, how much unpaid time off work have you used?

- ❍ Less than 1 week
- ❍ 1 week to 1 month
- ❍ 1-3 months
- ❍ 3-6 months
- ❍ 6 months or more
- ❍ None

15.19 In general, how difficult is it for you to balance work and manage your cancer treatment?

- ❍ Not at all difficult
- ❍ A little difficult
- ❍ Somewhat difficult
- ❍ Very difficult
- ❍ Extremely difficult
- ❍ Not applicable

SECTION 16: SOCIAL NEEDS

16.1 In the **last 12 months**, did you ever eat less than you felt you should have because there wasn't enough money for food?

- ❍ Yes
- ❍ No

16.2 In the **last 12 months**, has a utility company shut off your service for not paying your bills?

- ❍ Yes
- ❍ No

16.3 Are you worried that in the **next 2 months** you may not have stable housing?

- ❍ Yes
- ❍ No

16.4 In the **last 12 months**, have you ever had to go without health care because you didn't have transportation?

- ❍ Yes
- ❍ No

16.5 Generally, do you feel safe in your neighborhood?

- ❍ Yes
- ❍ No

SECTION 17: CAREGIVING RESPONSIBILITIES

17.1 Outside of your current employment, do you **currently** provide **regular** care for any family members or friends?

❍ Yes ⟶ **Go To Question 17.2** ❍ No ⟶ **Go To Section 18**

17.2 What is your relationship to the individual(s) you regularly provide care for? (Select all that apply)

I am his/her:

❍ Child
❍ Grandchild
❍ Parent
❍ Grandparent
❍ Other family member
(please specify) _____
❍ Friend
❍ Other individual
(please specify) _____

17.3 How many hours per week do you provide regular care for this individual / these individuals?

❍ 1-8 hours
❍ 9-20 hours
❍ 21-35 hours
❍ 36-72 hours
❍ 73 or more hours

SECTION 18: RELIGION

The next set of questions has to do with your religious practices.

18.1 In the **last 12 months**, how often did you attend church or other religious meetings?

❍ Never
❍ Once a year
❍ A few times a year
❍ A few times a month
❍ Once a week
❍ More than once a week
❍ Not answered / not applicable

18.2 In the **last 12 months**, how often did you spend time in private religious activities, such as prayer, meditation, or bible study?

❍ Rarely or never
❍ A few times a month
❍ Once a week
❍ Two or more times a week
❍ Daily
❍ More than once a day
❍ Not answered / not applicable

Thank you very much for filling out this survey - your answers are very important to us.

General Cancer Follow Up Survey
Version: 3
Revised: 8/13/2021

STUDY ID#: [ ]

PLEASE COMPLETE THE REQUESTED INFORMATION ON THE INSIDE OF THE BACK COVER

Yearly Survey

We will contact you again in a year to complete another follow up survey. Please provide your best contact information so that we are able to reach you. Providing this information is voluntary, and we will keep it confidential. We will only use this information if we cannot contact you using your current contact information. You will receive a $25 gift card for completing the follow up survey.

Home Phone: (____) _____ - _____

Cell Phone: (____) _____ - _____ ok to text? YES❍ NO❍

Work Phone: (____) _____ - _____

Email: _____

Gift Card

You will receive one $25 gift card for completing the survey. Please select which card you would like to receive as a thank you for your time.

❍ Meijer ❍ Target ❍ CVS

Comments

Please share any feedback or additional information you feel is important.

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