Research on Cancer Survivors

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

Cancer Survivor Follow Up Survey

Cancer Survivor Follow-Up Survey
Version: 2
Revised: 10/27/2022

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?

_____

1.3 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 Section 7**

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 7: SLEEP

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. Please take your best guess.

7.1. 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

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

Minutes to fall asleep: _____

7.3. 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

7.4. 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: _____

7.5. 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 snored loudly	❍	❍	❍	❍	❍
f. Felt too cold	❍	❍	❍	❍	❍
g. Felt too hot	❍	❍	❍	❍	❍
h. Had bad dreams	❍	❍	❍	❍	❍
i. Heard noises	❍	❍	❍	❍	❍
j. Had pain	❍	❍	❍	❍	❍
k. Have pets	❍	❍	❍	❍	❍
l. Other reason(s); Please describe: _____	❍	❍	❍	❍	❍
m. **During the past week,** how often did you take medicine (prescribed or "over the counter") to help you sleep?	❍	❍	❍	❍	❍
n. **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 the majority of days and nights in the past week.

7.6. 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

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

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

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

❍ Yes ❍ No

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

❍ 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?			Approximate age of diagnosis	Currently Being Treated?	
	Yes	No	Unsure		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 ❍ Gestational ❍ 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)? _____						

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.

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

❍ Yes ⟶ **Complete table below** ❍ No ⟶ **Go To Question 8.4**

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
	❍	❍	❍	❍
	❍	❍	❍	❍
	❍	❍	❍	❍
	❍	❍	❍	❍
	❍	❍	❍	❍
	❍	❍	❍	❍
	❍	❍	❍	❍
	❍	❍	❍	❍
	❍	❍	❍	❍
	❍	❍	❍	❍
	❍	❍	❍	❍
	❍	❍	❍	❍
	❍	❍	❍	❍
	❍	❍	❍	❍
	❍	❍	❍	❍
	❍	❍	❍	❍
	❍	❍	❍	❍
	❍	❍	❍	❍
	❍	❍	❍	❍

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.)

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

❍ Yes ⟶ **Go To Question 8.5** ❍ No ⟶ **Go To Section 9**

8.5 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

8.6 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: _____

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

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

SECTION 9: VITAMINS AND PAIN MEDICATIONS

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

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

❍ Yes ❍ No

9.2 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 cancer.

10.1 Have you received **any** treatment for your **INITIAL** cancer diagnosis **since your last survey** or are you **currently** receiving treatment for your initial cancer diagnosis?

❍ Yes → **Complete table below** ❍ No → **Go To Question 10.2**

Treatment	Treatment Received		Treatment START (Month / Year)	Treatment END (Month / Year) OR Check if currently receiving treatment	
	No	Yes			
Chemotherapy (oral or IV)	❍	❍	___ / _____	___ / _____	❍
Radiation therapy	❍	❍	___ / _____	___ / _____	❍
Hormone therapy	❍	❍	___ / _____	___ / _____	❍
Immunotherapy	❍	❍	___ / _____	___ / _____	❍
	No	**Yes**	**Surgery Date (Month / Year)**		
Surgery	❍	❍	___ / _____		
At which institution(s) did you receive your treatment?	_____				

10.2 Have you **ever** been diagnosed with a **RECURRENCE** of your cancer? A cancer recurrence means the same cancer came back after some period of time.

❍ Yes → Month / Year _____ / _____ ❍ No → **Go To Question 10.4**

10.3 Have you received **any** treatment for your cancer **RECURRENCE** or are you **currently** receiving treatment for your cancer recurrence?

❍ Yes → **Complete table below** ❍ No → **Go To Question 10.4**

Treatment	Treatment Received		Treatment START (Month / Year)	Treatment END (Month / Year) OR Check if currently receiving treatment	
	No	Yes			
Chemotherapy (oral or IV)	❍	❍	___ / _____	___ / _____	❍
Radiation therapy	❍	❍	___ / _____	___ / _____	❍
Hormone therapy	❍	❍	___ / _____	___ / _____	❍
Immunotherapy	❍	❍	___ / _____	___ / _____	❍
	No	**Yes**	**Surgery Date (Month / Year)**		
Surgery	❍	❍	___ / _____		
At which institution(s) did you receive your treatment?	_____				

10.4 Have you **ever** been diagnosed with any **OTHER** cancer?

❍ Yes → | Type of Cancer | Age at Diagnosis |
|---|---|
| | |
| | |
| | |

❍ No → **Go To Question 10.6**

10.5 Have you received **any** treatment for your **OTHER** cancer diagnosis, or are you **currently** receiving treatment for your other cancer diagnosis?

❍ Yes → **Complete table below** ❍ No → **Go To Question 10.6**

Treatment	Treatment Received		Treatment START (Month / Year)	Treatment END (Month / Year) OR Check if currently receiving treatment	
	No	Yes			
Chemotherapy (oral or IV)	❍	❍	___ / _____	___ / _____	❍
Radiation therapy	❍	❍	___ / _____	___ / _____	❍
Hormone therapy	❍	❍	___ / _____	___ / _____	❍
Immunotherapy	❍	❍	___ / _____	___ / _____	❍
	No	**Yes**	**Surgery Date (Month / Year)**		
Surgery	❍	❍	___ / _____		
At which institution(s) did you receive your treatment?	_____				

10.6 Have you **ever** received chemotherapy for **ANY CANCER DIAGNOSIS**?

❍ Yes → **Go To Question 10.7a** ❍ No → **Go To Section 11**

10.7a Since receiving chemotherapy have you experienced numbness, pain or tingling in your hands or feet?

❍ Yes, currently
❍ Yes, formerly
→ **Go To Question 10.7b**

❍ No, never → **Go To Question 10.7e**

10.7b 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.

10.7c Had you experienced these symptoms prior to your chemotherapy treatment? (Select all that apply)

❍ Yes, numbness
❍ Yes, pain
❍ Yes, tingling
→ **Go To Question 10.7d**

❍ No → **Go To Question 10.7e**

10.7d Has the numbness, pain, or tingling in your hands or feet worsened with chemotherapy treatment?

❍ Yes ❍ No

10.7e Since receiving chemotherapy have you ever experienced weakness in your arms or legs?

❍ Yes, currently
❍ Yes, formerly
→ **Go To Question 10.7f**

❍ No, never → **Go To Question 10.7i**

10.7f 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.

10.7g Had you experienced these symptoms prior to your chemotherapy treatment?

❍ Yes → **Go To Question 10.7h**

❍ No → **Go To Question 10.7i**

10.7h Has the weakness in your arms or legs worsened with chemotherapy treatment?

❍ Yes ❍ No

10.7i 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

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)	❍	❍	❍

11.2 Have you ever been referred for genetic testing by a physician?

❍ Yes ❍ No ❍ Don't know / not applicable

11.3 Have you ever undergone genetic testing?

❍ Yes ❍ No ❍ Don't know / not applicable

11.4 Have you ever met with a genetic counselor?

❍ Yes ❍ No ❍ Don't know / not applicable

Section 12: COVID-19

12.1. Have you ever tested positive for COVID-19?

❍ Yes → **Go to Question 12.2**

❍ No → **Go to Question 12.3**

❍ Not sure → **Go to Question 12.3**

12.2. Please check all that apply as a result of testing positive for COVID-19:

❍ I experienced no symptoms
❍ I experienced mild symptoms
❍ I experienced moderate to severe symptoms
❍ I was hospitalized due to COVID-19
❍ I was on a ventilator due to COVID-19

12.3. Have you received at least one dose of a COVID-19 vaccine?

❍ Yes ❍ No

12.4. Did you receive (or do you plan to receive) all required doses?

❍ Yes, received all required doses → **Go to Question 12.5**
❍ No, but plan to receive all required doses → **Go to Question 12.5**
❍ No, don't plan to receive all required doses → **Go to Question 12.6**

12.5. Did you receive (or do you plan to receive) a booster shot?

❍ Yes, received the booster → **Go to Section 13**
❍ No, but plan to receive the booster → **Go to Section 13**
❍ No, don't plan to receive the booster → **Go to Question 12.6**

12.6. Which of the following, if any, are reasons that you don't plan to receive all required doses and the booster, are unsure about getting a vaccine, probably will not get a vaccine, or definitely will not get a vaccine? *Select all that apply.*

❍ I am concerned about possible side effects of a COVID-19 vaccine
❍ I don't know if a COVID-19 vaccine will protect me
❍ I don't believe I need a COVID-19 vaccine
❍ My doctor has not recommended it
❍ I plan to wait and see if it is safe and may get it later
❍ I am concerned about the cost of a COVID-19 vaccine
❍ I don't trust COVID-19 vaccines
❍ I don't trust the government
❍ I don't think COVID-19 is that big of a threat
❍ It's hard for me to get a COVID-19 vaccine
❍ I believe one dose is enough to protect me
❍ I experienced side effects from the dose of COVID-19 vaccine I received
❍ Other (please specify) _____

SECTION 13: 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 14: 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 15: FATIGUE

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

For each item, please select the one option [per row] to indicate your response as it applies to 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 feel fatigued	❍	❍	❍	❍	❍
I feel weak all over	❍	❍	❍	❍	❍
I feel listless (“washed out”)	❍	❍	❍	❍	❍
I feel tired	❍	❍	❍	❍	❍
I have trouble starting things because I am tired	❍	❍	❍	❍	❍
I have trouble finishing things because I am tired	❍	❍	❍	❍	❍
I have energy	❍	❍	❍	❍	❍
I am able to do my usual activities	❍	❍	❍	❍	❍
I need to sleep during the day	❍	❍	❍	❍	❍
I am too tired to eat	❍	❍	❍	❍	❍
I need help doing my activities	❍	❍	❍	❍	❍
I am frustrated by being too tired to do the things I want to do	❍	❍	❍	❍	❍
I have to limit my social activity because I am tired	❍	❍	❍	❍	❍

SECTION 16: 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 17: PERSONAL STRESS

The next set of questions help us understand how different situations affect our feelings and perceived stress.

17.1. Please select one response per item as it applies to how often you have experienced each statement in the **last month:**

In the last month	Never	Almost never	Some-times	Fairly often	Very often
I have been upset because of something that happened unexpectantly	❍	❍	❍	❍	❍
I have felt unable to control the important things in my life	❍	❍	❍	❍	❍
I have felt nervous and stressed	❍	❍	❍	❍	❍
I have felt confident about my ability to handle my personal problems	❍	❍	❍	❍	❍
I have felt things were going my way	❍	❍	❍	❍	❍
I have found that I could not cope with all the things I had to do	❍	❍	❍	❍	❍
I have been able to control irritations in my life	❍	❍	❍	❍	❍
I have felt on top of things	❍	❍	❍	❍	❍
I have been angered because of things that happened that were outside of my control	❍	❍	❍	❍	❍
I felt difficulties were piling up so high that I could not overcome them	❍	❍	❍	❍	❍

SECTION 18: FINANCIAL CONCERNS

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

18.1 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

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

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

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

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

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

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

❍ Yes → **Go To Question 18.6** ❍ No → **Go To Question 18.7**

18.6 How long have you lived at your current address?

❍ Less than 6 months ❍ 6 months - 1 year

18.7 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.	❍	❍	❍	❍	❍

18.8 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

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

❍ Yes ❍ No

SECTION 19: SOCIAL NEEDS

19.1 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

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

❍ Yes ❍ No

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

❍ Yes ❍ No

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

❍ Yes ❍ No

19.5 Generally, do you feel safe in your neighborhood?

❍ Yes ❍ No

SECTION 20: CAREGIVING RESPONSIBILITIES

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

❍ Yes → **Go To Question 20.2** ❍ No → **Go To Section 21**

20.2 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) _____

20.3 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 21: RELIGION

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

21.1 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

21.2 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.

PLEASE TURN THE PAGE AND COMPLETE THE REQUESTED INFORMATION ON THE INSIDE OF THE BACK COVER

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

Cancer Survivor Follow Up Survey
Version: 2
Revised: 10/27/2022

STUDY ID#:

Yearly Survey

We will continue to contact you yearly to complete follow up surveys. 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: _____

CAPABLE Program

If you are not already regularly exercising, would you be interested in learning about a free exercise program for cancer survivors?

❍ Yes ❍ No

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.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

WAYNE STATE
School of Medicine