Detroit ROCS Pilot Study Year One Follow-Up Survey

Start of Block: Introduction to Survey

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

End of Block: Introduction to Survey

Start of Block: Demographics/ Background Information

Are you male or female?

- ○ Male
- ○ Female

Which of these terms best describes your current relationship or personal status?

- ○ Married
- ○ Living with a partner in a marriage-like relationship
- ○ Widowed
- ○ Divorced
- ○ Separated
- ○ Never married

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
- ○ Disability
- ○ Other (specify) _____

What is/was your usual occupation?

_____

End of Block: Demographics/ Background Information

Start of Block: Medical History

The next items will ask about your medical history in the past year.

What is your current weight (in pounds)? Please enter only numbers.

For example if you weigh 250 lbs., enter the numbers 250 only.

_____

Has a doctor told you that you have any of the following medical conditions? Please check all that apply and if prompted, give your approximate age at diagnosis and medication information if known.

	Medical Condition		
	Yes	No	Unsure

Anxiety	○	○	○
Arthritis	○	○	○
Cirrhosis	○	○	○
Congestive heart failure	○	○	○
COPD (chronic obstructive pulmonary disease)	○	○	○
Crohn's disease or ulcerative colitis	○	○	○
Depression	○	○	○
Diabetes	○	○	○
Emphysema	○	○	○
Fracture, **over age 50**	○	○	○
Heart attack (myocardial infarction)	○	○	○
Hepatitis (any type)	○	○	○
High cholesterol	○	○	○
HIV or AIDS	○	○	○
Hypertension (high blood pressure)	○	○	○
Lupus (systemic lupus erythermatosus)	○	○	○
Osteoporosis	○	○	○
Peripheral vascular disease	○	○	○

Stroke	○	○	○
Thyroid problem	○	○	○
Any other medical condition not previously listed	○	○	○

You indicate that a doctor has informed you that you have anxiety. Please tell us your approximate age at diagnosis and if you are currently being treated for the condition, and/or taking medication for this condition.

	Approximate Age at Diagnosis	Are you currently being treated for anxiety?		Are you currently taking any medication(s) for anxiety?	
	Answer 1	Yes	No	Yes	No
Anxiety		○	○	○	○

	What is the name of the medication(s) you are taking for anxiety?	Please specify the medication(s) taken for anxiety if it was not previously listed	For how long have you taken this medication for anxiety?			
			Less than 6 Months	6 Months to Less than 1 Year	1 to 3 Years	More than 3 Years
Anxiety Medication 1	▼ Ativan/ Lorazepam ... Other, Please specify		○	○	○	○
Anxiety Medication 2	▼ Ativan/ Lorazepam ... Other, Please specify		○	○	○	○
Anxiety Medication 3	▼ Ativan/ Lorazepam ... Other, Please specify		○	○	○	○

You indicate that a doctor has informed you that you have arthritis, please specify type (e.g. rheumatoid or osteoarthritis), approximate age at diagnosis and if you are currently being treated for the condition.

	Approximate	Are you currently being treated?		Specify	Are you currently taking any medication for arthritis?	
	age at diagnosis?	Yes	No	type:	Yes	No
Arthritis		○	○		○	○

	What is the name of the medication(s) you are taking for arthritis?	Please specify the medication(s) taken for arthritis if it was not previously listed	For how long have you taken this medication for arthritis?			
		Answer 1	Less than 6 Months	6 Months to Less than 1 Year	1 to 3 Years	More than 3 Years
Arthritis Medication 1	▼ Celebrex/ Celecoxib ... Other, Please specify		○	○	○	○
Arthritis Medication 2	▼ Celebrex/ Celecoxib ... Other, Please specify		○	○	○	○
Arthritis Medication 3	▼ Celebrex/ Celecoxib ... Other, Please specify		○	○	○	○

You indicate that a doctor has informed you that you have cirrhosis, please specify approximate age at diagnosis and if you are currently being treated for the condition:

	Approximate	Are you currently being treated?

	age at diagnosis?	Yes	No
Cirrhosis		○	○

You indicate that a doctor has informed you that you have congestive heart failure, please specify approximate age at diagnosis and if you are currently being treated for the condition:

	Approximate	Are you currently being treated?		Are you currently taking any medication for this condition?	
	age at diagnosis?	Yes	No	Yes	No
Congestive Heart Failure		○	○	○	○

	What is the name of the medication(s) you are taking for Congestive Heart Failure?	Please specify the medication(s) taken for congestive heart failure if it was not previously listed	For how long have you taken this medication for congestive heart failure?			
		Answer 1	Less than 6 Months	6 Months to Less than 1 Year	1 to 3 Years	More than 3 Years
Congestive Heart Failure (CHF) Medication 1	▼ Coreg/ Carvedilol ... Other, Please specify		○	○	○	○
CHF Medication 2	▼ Coreg/ Carvedilol ... Other, Please specify		○	○	○	○
CHF Medication 3	▼ Coreg/ Carvedilol ... Other, Please specify		○	○	○	○

You indicate that a doctor has informed you that you have COPD (chronic obstructive pulmonary disease), please specify approximate age at diagnosis and if you are currently being treated for the condition:

	Approximate	Are you currently being treated?		Are you currently taking any medications for COPD?	
	age at diagnosis?	Yes	No	Yes	No
COPD (Chronic obstructive pulmonary disease)		○	○	○	○

	What is the name of the medication(s) you are taking for COPD?	Please specify the medication(s) taken for COPD if it was not previously listed.	For how long have you taken this medication/ these medications for COPD?			
		Specify	Less than 6 Months	6 Months to Less than 1 Year	1 to 3 Years	More than 3 Years
COPD Medication 1	▼ Fluticasone/ Budesonide ... Other, Please specify		○	○	○	○
COPD Medication 2	▼ Fluticasone/ Budesonide ... Other, Please specify		○	○	○	○
COPD Medication 3	▼ Fluticasone/ Budesonide ... Other, Please specify		○	○	○	○

You indicate that a doctor has informed you that you have Crohn's disease or ulcerative colitis, please specify approximate age at diagnosis and if you are currently being treated for the condition:

	Approximate	Are you currently being treated?		Are you currently taking any medications for Crohn's or Ulcerative colitis?	
	age at diagnosis?	Yes	No	Yes	No
Crohn's disease or ulcerative colitis		○	○	○	○

	What is the name of the medication(s) you are taking for Crohn's/ Ulcerative colitis?	Please specify the medication(s) taken if it was not previously listed.	For how long have you taken medication for Crohn's Disease or Ulcerative colitis?			
		Specify	Less than 6 Months	6 Months to Less than 1 Year	1 to 3 Years	More than 3 Years
Crohn's Disease or Ulcerative Colitis Medication 1	▼ Apriso/ Asacol/ Pentasa ... Other, Please specify		○	○	○	○
Medication 2	▼ Apriso/ Asacol/ Pentasa ... Other, Please specify		○	○	○	○
Medication 3	▼ Apriso/ Asacol/ Pentasa ... Other, Please specify		○	○	○	○

You indicate that a doctor has informed you that you have depression, please specify approximate age at diagnosis and if you are currently being treated for the condition:

	Approximate	Are you currently being treated?		Are you currently taking any medication for depression?	
	age at diagnosis?	Yes	No	Yes	No
Depression		○	○	○	○

	What is the name of the medication(s) you are taking for depression?	Please specify the medication(s) taken if it was not previously listed.	For how long have you taken medication for depression?			
		Specify	Less than 6 Months	6 Months to Less than 1 Year	1 to 3 Years	More than 3 Years
Depression Medication 1	▼ Celexa/ Citalopram ... Other, Please specify		○	○	○	○
Depression Medication 2	▼ Celexa/ Citalopram ... Other, Please specify		○	○	○	○
Depression Medication 3	▼ Celexa/ Citalopram ... Other, Please specify		○	○	○	○

You indicate that a doctor has informed you that you have diabetes, please specify type (e.g. type 1 or type 2), approximate age at diagnosis and if you are currently being treated for the condition:

	Approximate	Are you currently being treated?		Specify		Are you currently taking any medications for diabetes?	
	age at diagnosis?	Yes	No	Type 1	Type 2	Yes	No
Diabetes		○	○	○	○	○	○

Display This Question:

If You indicate that a doctor has informed you that you have diabetes, please specify type (e.g. typ... : Specify = Type 1

And You indicate that a doctor has informed you that you have diabetes, please specify type (e.g. typ... : Are you currently taking any medications for diabetes? = Yes

	What is the name of the medication(s) you are taking for diabetes?	Please specify the medication(s) taken if it was not previously listed.	For how long have you taken this medication for diabetes?			
		Specify	Less than 6 Months	6 Months to Less than 1 Year	1 to 3 Years	More than 3 Years
Type 1 Diabetes Medication 1	▼ Afrezza/ Inhaled Insulin ... Other, Please specify		○	○	○	○
Diabetes Medication 2	▼ Afrezza/ Inhaled Insulin ... Other, Please specify		○	○	○	○
Diabetes Medication 3	▼ Afrezza/ Inhaled Insulin ... Other, Please specify		○	○	○	○

Display This Question:

If You indicate that a doctor has informed you that you have diabetes, please specify type (e.g. typ... : Specify = Type 2

And You indicate that a doctor has informed you that you have diabetes, please specify type (e.g. typ... : Are you currently taking any medications for diabetes? = Yes

	What is the name of the medication(s) you are taking for diabetes?	Please specify the medication(s) taken if it was not previously listed.	For how long have you taken this medication for diabetes?			
		Specify	Less than 6 Months	6 Months to Less than 1 Year	1 to 3 Years	More than 3 Years
Type 2 Diabetes Medication 1	▼ Actos/ Pioglitazone ... Other, specify		○	○	○	○
Diabetes Medication 2	▼ Actos/ Pioglitazone ... Other, specify		○	○	○	○
Diabetes Medication 3	▼ Actos/ Pioglitazone ... Other, specify		○	○	○	○

You indicate that a doctor has informed you that you have emphysema, please specify approximate age at diagnosis and if you are currently being treated for the condition:

	Approximate	Are you currently being treated?		Are you currently taking any medication for emphysema?	
	age at diagnosis?	Yes	No	Yes	No
Emphysema		○	○	○	○

	What is the name of the medication(s) you are taking for emphysema?	Please specify the medication(s) taken if it was not previously listed to the left.	For how long have you taken this medication for emphysema?			
		Specify	Less than 6 Months	6 Months to Less than 1 Year	1 to 3 Years	More than 3 Years
Emphysema Medication 1	▼ Aminophylline ... Other, specify		○	○	○	○
Medication 2	▼ Aminophylline ... Other, specify		○	○	○	○
Medication 3	▼ Aminophylline ... Other, specify		○	○	○	○

You indicate that a doctor has informed you that you have fractured a bone over the age 50. Please specify location (e.g. arm, hip, wrist), approximate age when you fractured the bone.

	Approximate	Specify

	age at diagnosis?	Bone/ Location of fracture (ex: hip, wrist, etc..)
Fracture over age 50		

You indicate that a doctor has informed you that you had a heart attack (myocardial infarction). Please specify the approximate age of occurrence and if you are currently being treated for the condition:

	Approximate	Are you currently being treated?		Are you currently taking any medication for the heart attack/ myocardial infarction?	
	age at diagnosis?	Yes	No	YES	No
Heart attack (myocardial infarction)		○	○	○	○

	What is the name of the medication(s) you are taking for a myocardial infarction (heart attack)?	Please specify the medication(s) taken if it was not previously listed to the left.	For how long have you taken this medication for myocardial infarction (heart attack)?			
		Specify	Less than 6 Months	6 Months to Less than 1 Year	1 to 3 Years	More than 3 Years
Heart attack Medication 1	▼ Activase/ Alteplase ... Other, specify		○	○	○	○
Medication 2	▼ Activase/ Alteplase ... Other, specify		○	○	○	○
Medication 3	▼ Activase/ Alteplase ... Other, specify		○	○	○	○

You indicate that a doctor has informed you that you have hepatitis (any type). Please specify approximate age at diagnosis and if you are currently being treated for the condition:

	Approximate	Are you currently being treated?		Are you currently taking any medication for Hepatitis?		Which type of Hepatitis do you have?			
	age at diagnosis?	Yes	No	Yes	No	A	B	C	Other
Hepatitis (any type)		○	○	○	○	○	○	○	○

	What is the name of the medication(s) you are taking for Hepatitis?	Please specify the medication(s) taken if it was not previously listed to the left.	For how long have you taken this medication for Hepatitis?			
		Specify	Less than 6 Months	6 Months to Less than 1 Year	1 to 3 Years	More than 3 Years
Hepatitis Medication 1	▼ IGIM/ GamaSTAN S/D/ Immuneglobin ... Telaprevir/ Incivek		○	○	○	○
Medication 2	▼ IGIM/ GamaSTAN S/D/ Immuneglobin ... Telaprevir/ Incivek		○	○	○	○
Medication 3	▼ IGIM/ GamaSTAN S/D/ Immuneglobin ... Telaprevir/ Incivek		○	○	○	○

You indicate that a doctor has informed you that you have high cholesterol. Please specify your approximate age at diagnosis and if you are currently being treated for the condition.

	Approximate	Are you currently being treated?		Are you currently taking any medication for high cholesterol?	
	age at diagnosis?	Yes	No	Yes	No
High cholesterol		○	○	○	○

	What is the name of the medication(s) you are taking for high cholesterol?	Please specify the medication(s) taken if it was not previously listed to the left.	For how long have you taken this medication for high cholesterol?			
		Specify	Less than 6 Months	6 Months to Less than 1 Year	1 to 3 Years	More than 3 Years
High Cholesterol Medication 1	▼ Crestor/ Rosuvasatin ... Other, specify		○	○	○	○
Medication 2	▼ Crestor/ Rosuvasatin ... Other, specify		○	○	○	○
Medication 3	▼ Crestor/ Rosuvasatin ... Other, specify		○	○	○	○

You indicate that a doctor has informed you that you have HIV or AIDS, please specify approximate age at diagnosis and if you are currently being treated for the condition:

	Approximate	Are you currently being treated?		Are you currently taking any medication for HIV or AIDS?	
	age at diagnosis?	Yes	No	Yes	No
HIV or AIDS		○	○	○	○

	What is the name of the medication(s) you are taking for HIV or AIDS?	Please specify the medication(s) taken if it was not previously listed to the left.	For how long have you taken this medication for HIV or AIDS?			
		Specify	Less than 6 Months	6 Months to Less than 1 Year	1 to 3 Years	More than 3 Years
HIV/ AIDS Medication 1	▼ Abcavir/ Ziagen ... Other, specify		○	○	○	○
Medication 2	▼ Abcavir/ Ziagen ... Other, specify		○	○	○	○
Medication 3	▼ Abcavir/ Ziagen ... Other, specify		○	○	○	○

You indicate that a doctor has informed you that you have hypertension (high blood pressure). Please specify approximate age at diagnosis and if you are currently being treated for the condition.

	Approximate	Are you currently being treated?		Are you currently taking any medication for hypertension?	
	age at diagnosis?	Yes	No	Yes	No
Hypertension (high blood pressure)		○	○	○	○

	What is the name of the medication(s) you are taking for Hypertension/ High Blood Pressure?	Please specify the medication(s) taken if it was not previously listed to the left.	For how long have you taken this medication for Hypertension/ High Blood Pressure?			
		Specify	Less than 6 Months	6 Months to Less than 1 Year	1 to 3 Years	More than 3 Years
Hypertension Medication 1	▼ Atenolol/ Tenormin ... Other, specify		○	○	○	○
Medication 2	▼ Atenolol/ Tenormin ... Other, specify		○	○	○	○
Medication 3	▼ Atenolol/ Tenormin ... Other, specify		○	○	○	○

You indicate that a doctor has informed you that you have Lupus (systemic lupus erythematosus). Please specify your approximate age at diagnosis and if you are currently being treated for the condition.

	Approximate	Are you currently being treated?		Are you currently taking any medication for Lupus?	
	age at diagnosis?	Yes	No	Yes	No
Lupus (systemic lupus erythematosus)		○	○	○	○

	What is the name of the medication(s) you are taking for Lupus?	Please specify the medication(s) taken if it was not previously listed to the left.	For how long have you taken this medication?			
		Specify	Less than 6 Months	6 Months to Less than 1 Year	1 to 3 Years	More than 3 Years
Lupus Medication 1	▼ Benylsta/ Belimumab ... Other, specify		○	○	○	○
Medication 2	▼ Benylsta/ Belimumab ... Other, specify		○	○	○	○
Medication 3	▼ Benylsta/ Belimumab ... Other, specify		○	○	○	○

You indicate that a doctor has informed you that you have osteoporosis. Please specify your approximate age at diagnosis and if you are currently being treated for the condition.

	Approximate	Are you currently being treated?		Are you currently taking any medication for osteoporosis?	
	age at diagnosis?	Yes	No	Yes	No
Osteoporosis		○	○	○	○

	What is the name of the medication(s) you are taking for osteoporosis?	Please specify the medication(s) taken if it was not previously listed to the left.	For how long have you taken this medication for osteoporosis?			
		Specify	Less than 6 Months	6 Months to Less than 1 Year	1 to 3 Years	3 Years or More
Osteoporosis Medication 1	▼ Actonel/ Risedronate ... Premarin/ Enjuvia/ Conjugated Estrogen		○	○	○	○
Medication 2	▼ Actonel/ Risedronate ... Premarin/ Enjuvia/ Conjugated Estrogen		○	○	○	○
Medication 3	▼ Actonel/ Risedronate ... Premarin/ Enjuvia/ Conjugated Estrogen		○	○	○	○

You indicate that a doctor has informed you that you have peripheral vascular disease. Please specify approximate age at diagnosis and if you are currently being treated for the condition.

	Approximate	Are you currently being treated?		Are you currently taking any medication for this condition?	
	age at diagnosis?	Yes	No	Yes	No
Peripheral vascular disease		○	○	○	○

	What is the name of the medication(s) you are taking for peripheral vascular disease?	Please specify the medication(s) taken if it was not previously listed to the left.	For how long have you taken this medication?			
		Specify	Less than 6 Months	6 Months to Less than 1 Year	1 to 3 Years	More than 3 Years
Peripheral Vascular Disease Medication 1	▼ Aspirin ... Other		○	○	○	○
Medication 2	▼ Aspirin ... Other		○	○	○	○
Medication 3	▼ Aspirin ... Other		○	○	○	○

You indicate that a doctor has informed you that you have had a stroke. Please specify approximate age of diagnosis and if you are currently being treated for the condition.

	Approximate	Are you currently being treated?		Are you currently taking any medication for this condition?	
	age at diagnosis?	Yes	No	Yes	No
Stroke		○	○	○	○

	What is the name of the medication(s) you are taking?	Please specify the medication(s) taken if it was not previously listed to the left.	For how long have you taken this medication?			
		Specify	Less than 6 Months	6 Months to Less than 1 Year	1 to 3 Years	More than 3 Years
Stroke Medication 1	▼ Aggrenox ... Other, specify		○	○	○	○
Medication 2	▼ Aggrenox ... Other, specify		○	○	○	○
Medication 3	▼ Aggrenox ... Other, specify		○	○	○	○

You indicate that a doctor has informed you that you have a thyroid condition. Please specify type of thyroid condition, approximate age and if you are currently being treated for the condition.

	Approximate	Are you currently being treated?		Specify			Are you currently taking any medications for your thyroid condition?	
	age at diagnosis?	Yes	No	Hypothyroidism	Hyperthyroidism	Other	Yes	No
Thyroid condition		○	○	○	○	○	○	○

Hypothyroidism

	What is the name of the medication(s) you are taking?	Please specify the medication(s) taken if it was not previously listed to the left.	For how long have you taken this medication?			
		Specify	Less than 6 Months	6 Months to Less than 1 Year	1 to 3 Years	More than 3 Years
Thyroid Medication 1	▼ Armour/ Thyoid ... Thyrolar/ Liotrix		○	○	○	○
Medication 2	▼ Armour/ Thyoid ... Thyrolar/ Liotrix		○	○	○	○
Medication 3	▼ Armour/ Thyoid ... Thyrolar/ Liotrix		○	○	○	○

Hyperthyroidism

	What is the name of the medication(s) you are taking?	Please specify the medication(s) taken if it was not previously listed to the left.	For how long have you taken this medication?			
		Specify	Less than 6 Months	6 Months to Less than 1 Year	1 to 3 Years	More than 3 Years
Thyroid Medication 1	▼ I- 131/ Sodium Iodide 131 ... Other, specify		○	○	○	○
Medication 2	▼ I- 131/ Sodium Iodide 131 ... Other, specify		○	○	○	○
Medication 3	▼ I- 131/ Sodium Iodide 131 ... Other, specify		○	○	○	○

Other thyroid condition

	Please specify the medication(s) you take for your thyroid condition.	For how long have you taken this medication?			
	Specify	Less than 6 Months	6 Months to Less than 1 Year	1 to 3 Years	More than 3 Years
Thyroid Medication 1		○	○	○	○
Medication 2		○	○	○	○
Medication 3		○	○	○	○

You indicate that a doctor has informed you that you another medical condition. Please specify the medical condition, approximate age at diagnosis and if you are currently being treated for the condition.

	Approximate	Are you currently being treated?		Specify	Are you currently taking medications for this condition?		If yes, please specify the medication you take for this condition.	For how long have you taken this medication?			
	age at diagnosis?	Yes	No	condition:	Yes	No	Yes	Less than 6 Months	6 Months to Less than 1 Year	1 to 3 Years	More than 3 Years
Other medical condition 1		○	○		○	○		○	○	○	○
Other medical condition 2		○	○		○	○		○	○	○	○
Other medical condition 3		○	○		○	○		○	○	○	○

Please list all other medications you are currently taking if you did not previously list the medication with a condition in the last section.

	Specify	For how long have you taken this medication?			
	Medication Name	Less than 6 Months	6 Months to Less than 1 Year	1 to 3 Years	More than 3 Years
Medication 1		○	○	○	○
Medication 2		○	○	○	○
Medication 3		○	○	○	○
Medication 4		○	○	○	○
Medication 5		○	○	○	○

End of Block: Medical History

Start of Block: Family History of Cancer

Next, we would like to know about cancer diagnoses occurring in your family members over the past year.

In the previous survey if you reported that any female family members had been diagnosed with cancer that information will appear below. Please edit the responses if any previous information was entered incorrectly or to add an additional female family member who has been diagnosed with cancer since you last completed the survey.

Please only include responses for your biological mother, grandmothers, full-blood sisters (sisters who share both of your same biological parents) and biological daughters.

	Relationship to you	Type of cancer	Approximate age at diagnosis
	(e.g. mother, sister, daughter)	(e.g. breast, colon, lung)	(in years)
Relative 1			
Relative 2			
Relative 3			
Relative 4			
Relative 5			
Relative 6			

In the previous survey if you reported that any male family members had been diagnosed with cancer that information will appear below. Please edit the responses if any previous information was entered incorrectly or to add an additional male family member who has been diagnosed with cancer since you last completed the survey.

Please only include responses for your biological father, grandfathers, full-blood brothers (brothers who share both of your same biological parents) and biological sons.

	Relationship to you	Type of cancer	Approximate age at diagnosis
	(e.g. father, brother, son)	(e.g. prostate, colon, lung)	(in years)
Relative 1			
Relative 2			
Relative 3			
Relative 4			
Relative 5			
Relative 6			

End of Block: Family History of Cancer

Start of Block: Health Behaviors- Physical Activity

The next section asks about your health behaviors including physical activity, tobacco use and alcohol use.

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

- ○ Yes
- ○ No

Vigorous activities are those during which you can only say a few words without stopping to catch your breath. Examples of vigorous activities include aerobic dance or fast dancing; jumping rope; race walking, jogging, or running; swimming laps; tennis; heavy yard work; or any other activity that causes large increases in breathing or heart rate. In the past 4 weeks, did you get regular vigorous exercise (that is, at least once a week) through activities such as running, aerobics, heavy yard work, tennis, or any other activity that causes large increases in breathing or heart rate?

- ○ Yes
- ○ No

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

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

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

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

Moderate activities are those during which you can talk but you can't sing. Examples of moderate activities include walking briskly; biking on level ground or with few hills; playing golf; ballroom or line dancing; general gardening; using a manual wheelchair; or any other activity that causes small increases in breathing or heart rate.

In the past 4 weeks did you do any moderate activities at least once a week?

- ○ Yes
- ○ No

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 or more times

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

- ○ Under 10 minutes
- ○ 10-19 minutes
- ○ 20-29 minutes
- ○ 30-44 minutes
- ○ 45-59 minutes
- ○ 60 minutes or more

End of Block: Health Behaviors- Physical Activity

Start of Block: Health Behaviors- Diet

Now think about the foods you ate or drank during the past month, that is, the past 30 days, including meals and snacks.

During the past month, 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

During the past month, how many servings of vegetables like green salad, green beans, tomatoes, carrots, onions, or broccoli did you eat per day? (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). Do not count fried potatoes.

- ○ 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 month, how often did you eat processed meat, such as ham, bologna, salami, hot dogs, bacon or sausage?

- ○ 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

In the past month, how often did you eat other red meat, such as steak, hamburger, pork, lamb, alone or in other dishes such as sandwiches, pasta or pizza?

- ○ 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

In the past month, how often did you 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.

- 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

In the past month, how often did you eat fast food such as McDonald's, KFC or Taco Bell?

- 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

In the past month, how often did you eat sweets or desserts such a cookies, cake, pie or ice cream?

- 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

End of Block: Health Behaviors- Diet

Start of Block: 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.

Do you currently smoke cigarettes on a regular basis? Regular is defined as at least one cigarette a day for the last month.

- ○ Yes
- ○ No

How many cigarettes do you smoke on an average day?
Note: 1 pack = 20 cigarettes

- ○ 1 to 5 cigarettes per day
- ○ 5 to 10 cigarettes per day
- ○ 10 to 15 cigarettes per day
- ○ 15 to 20 cigarettes per day (about 1 pack per day)
- ○ More than 1 pack but less than 2 packs per day
- ○ 2 packs or more per day

Do you live in the same household with someone who smokes cigarettes regularly while in your presence?

- ○ Yes
- ○ No

End of Block: Health Behaviors- Tobacco

Start of Block: Health Behaviors- Alcohol

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

In the past month, have you consumed alcoholic beverages such as beer, wine, or liquor?

- ○ Yes
- ○ No

In the past month, how many of each type of alcoholic beverage did you consume per week, on average?

	Number of times 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	

End of Block: Health Behaviors- Alcohol

Start of Block: Vitamins, Pain Medications & Hormone Therapy

The next items ask about your use of vitamins, supplements and medications.

Do you currently take a daily multi-vitamin?

- ○ Yes
- ○ No

Do you currently take any other vitamin or supplement daily?

- ○ Yes, Please specify on the next page
- ○ No

What other vitamin or supplement do you currently take daily? Please check all that apply:

- [ ] Stress-tabs or B-Complex
- [ ] Antioxidant combination
- [ ] Vitamin A
- [ ] Vitamin C
- [ ] Vitamin D
- [ ] Vitamin E
- [ ] Calcium
- [ ] Other vitamin(s) or supplement(s) (Please specify):

_____

Have you ever taken hormone therapy (HT), hormones that are taken around the time of or after menopause for women and in men for symptoms of low testosterone?

Please include only HT for any condition unrelated to your cancer diagnosis. You will be asked about hormone use related to cancer treatment in a later section. Only include hormones NOT related to cancer treatment for this question.

- ○ Yes
- ○ No

For how long did you take HT?

- ○ Less than 3 months
- ○ 3 months to 1 year
- ○ 1 to 3 years
- ○ >3 to 5 years
- ○ More than 5 years

What was the name of the hormone you took or are currently taking?

_____

Which form of the hormone(s) did you use/ do you use?

- [ ] Oral pill
- [ ] Cream
- [ ] Suppository
- [ ] Skin patch
- [ ] Shot
- [ ] Other, please specify _____

In the past year, have you taken any of the following medications 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.

	Did you take?		If Yes,, How Many Days per week?			Click to write Column 3
	Yes	No	3 days a week or less	4-6 days a week	7 days a week	For how many months in the past year?

Acetaminophen (such as Tylenol or Aspirin-free Excedrin)	○	○	○	○	○	
Aspirin (such as Anacin, Bufferin, Alka-Seltzer, Bayer, or Excedrin) baby or low-dose aspirin (81mg)	○	○	○	○	○	
Ibuprofen (such as Advil, Motrin, Nuprin, or Mediprin)	○	○	○	○	○	
Naproxen (such as Aleve, Naprosyn, Anaprox, or Naprelan)	○	○	○	○	○	
Other pain relievers (such as piroxicam or indomethacin)	○	○	○	○	○	
Fiber products (such as Metamucil, Citrucel, FiberCon, or Fiberall)	○	○	○	○	○	

End of Block: Vitamins, Pain Medications & Hormone Therapy

Start of Block: FACT- General (All Sites)

Below is a list of statements about physical, social, emotional, and functional well-being that other cancer patients and survivors have said are important.

Please mark one response per line as it applies to the past 7 days.

Physical well-being

	Not at all	A little bit	Some what	Quite a bit	Very much
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

	Not at all	A little bit	Some what	Quite a bit	Very much
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 check 'Prefer not to answer'.

	Not at all	A little bit	Some what	Quite a bit	Very much	Prefer not to Answer
I am satisfied with my sex life	○	○	○	○	○	○

Emotional well-being

	Not at all	A little bit	Some what	Quite a bit	Very much
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

	Not at all	A little bit	Some what	Quite a bit	Very much
I am able to work (include work at home)	○	○	○	○	○
My work (include work at home) is fulfiling	○	○	○	○	○
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	○	○	○	○	○

End of Block: FACT- General (All Sites)

Start of Block: FACT- Breast

Below is a list of statements relating to issues that other breast cancer patients and survivors have said are important.
Please mark one response per line as it applies to the **past 7 days**.

	Not at all	A little bit	Some what	Quite a bit	Very much
I have been short of breath	○	○	○	○	○
I am self-conscious about the way I dress	○	○	○	○	○
One or both of my arms are swollen or tender	○	○	○	○	○
I feel sexually attractive	○	○	○	○	○
I am bothered by hair loss	○	○	○	○	○
I worry that other members of my family might someday get the same illness I have	○	○	○	○	○
I worry about the effect of stress on my illness	○	○	○	○	○
I am bothered by a change in weight	○	○	○	○	○
I am able to feel like a woman	○	○	○	○	○
I have certain parts of my body where I experience pain	○	○	○	○	○

End of Block: FACT- Breast

Start of Block: FACT- Prostate

Below is a list of statements relating to issues that other prostate cancer patients and survivors have said are important.

Please mark one response per line as it applies to the **past 7 days**.

	Not at all	A little bit	Some what	Quite a bit	Very much
I am losing weight	○	○	○	○	○
I have a good appetite	○	○	○	○	○
I have aches and pains that bother me	○	○	○	○	○
I have certain parts of my body where I experience pain	○	○	○	○	○
My pain keeps me from doing things I want to do	○	○	○	○	○
I am satisfied with my present comfort level	○	○	○	○	○
I am able to feel like a man	○	○	○	○	○
I have trouble moving my bowels	○	○	○	○	○
I have difficulty urinating	○	○	○	○	○
I urinate more frequently than usual	○	○	○	○	○
My problems with urinating limit my activities	○	○	○	○	○
I am able to have and maintain an erection	○	○	○	○	○

End of Block: FACT- Prostate

Start of Block: FACT- Colorectal

Below is a list of statements relating to issues that other colorectal cancer patients and survivors have said are important.

Please mark one response per line as it applies to the **past 7 days**.

	Not at all	A little bit	Some what	Quite a bit	Very much
I have swelling or cramps in my stomach area	○	○	○	○	○
I am losing weight	○	○	○	○	○
I have control of my bowels	○	○	○	○	○
I can digest my food well	○	○	○	○	○
I have diarrhea	○	○	○	○	○
I have a good appetite	○	○	○	○	○
I like the appearance of my body	○	○	○	○	○

Do you have an ostomy appliance?

- ○ Yes
- ○ No

The next two items are about your ostomy appliance. Please mark one response per line.

	Not at all	A little bit	Somewhat	Quite a bit	Very much
I am embarrassed by my ostomy appliance	○	○	○	○	○
Caring for my ostomy appliance is difficult	○	○	○	○	○

End of Block: FACT- Colorectal

Start of Block: FACT- Lung

Below is a list of statements relating to issues that other lung cancer patients and survivors have said are important.

Please mark one response per line as it applies to the **past 7 days**.

	Not at all	A little bit	Some-what	Quite a bit	Very much
I have been short of breath	○	○	○	○	○
I am losing weight	○	○	○	○	○
My thinking is clear	○	○	○	○	○
I have been coughing	○	○	○	○	○
I am bothered by hair loss	○	○	○	○	○
I have a good appetite	○	○	○	○	○
I feel tightness in my chest	○	○	○	○	○
Breathing is hard for me	○	○	○	○	○

I regret my smoking

- ○ Not at all
- ○ A little bit
- ○ Somewhat
- ○ Quite a bit
- ○ Very much
- ○ Never Smoked Cigarettes

End of Block: FACT- Lung

Start of Block: PROMIS 29- Profile v2.0- Anxiety, Depression, Pain & Fatigue

Please respond to each question or statement by marking one answer per row.

	Without any difficulty	With a little difficulty	With some difficulty	With much difficulty	Unable to do
Are you able to do chores such as vacuuming or yard work?	○	○	○	○	○
Are you able to go up and down stairs at a normal pace?	○	○	○	○	○
Are you able to go for a walk of at least 15 minutes?	○	○	○	○	○
Are you able to run errands and shop	○	○	○	○	○

The next several questions ask about your mental and emotional well-being, pain, fatigue and social interactions.

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

In the past 7 days...

	Never	Rarely	Sometimes	Often	Always
I felt fearful	○	○	○	○	○
I found it hard to focus on anything other than my anxiety	○	○	○	○	○
My worries overwhelmed me	○	○	○	○	○
I felt uneasy	○	○	○	○	○

In the past 7 days...

	Never	Rarely	Sometimes	Often	Always
I felt worthless	○	○	○	○	○
I felt helpless	○	○	○	○	○
I felt depressed	○	○	○	○	○
I felt hopeless	○	○	○	○	○

In the past 7 days...

	Not at all	A little bit	Some what	Quite a bit	Very much
I felt fatigued	○	○	○	○	○
I had trouble starting things because I am tired	○	○	○	○	○
How run-down did you feel on average?	○	○	○	○	○
How fatigued were you on average?	○	○	○	○	○

In the past 7 days...

	Not at all	A little bit	Some what	Quite a bit	Very much
How much did pain interfere with your day to day activities?	○	○	○	○	○
How much did pain interfere with work around the home?	○	○	○	○	○
How much did pain interfere with your ability to participate in social activities?	○	○	○	○	○
How much did pain interfere with your household chores?	○	○	○	○	○

End of Block: PROMIS 29- Profile v2.0- Anxiety, Depression, Pain & Fatigue

Start of Block: PROMIS Social Support (emotional/ instrumental- short form)

The next several items are about the social support you might get from people in your life.

Please respond to each question or statement by marking one answer per row.

	Never	Rarely	Sometimes	Usually	Always
I have someone who will listen to me when I need to talk	○	○	○	○	○
I have someone to confide in or talk to about myself or my problems	○	○	○	○	○
I have someone who makes me feel appreciated	○	○	○	○	○
I have someone to talk to when I have a bad day	○	○	○	○	○
I have someone who understands my problems	○	○	○	○	○
I have someone I trust to talk with about my feelings	○	○	○	○	○

Please respond to each question by marking one answer per row.

	Never	Rarely	Sometimes	Usually	Always
Do you have someone to help you if you are confined to bed?	○	○	○	○	○
Do you have someone to take you to the doctor if you need it?	○	○	○	○	○
Do you have someone to help with your daily chores if you are sick?	○	○	○	○	○
Do you have someone to run errands if you need it?	○	○	○	○	○

End of Block: PROMIS Social Support (emotional/ instrumental- short form)

Start of Block: PROMIS Social Isolation

The next several items are about your feelings of connection to others.

Please respond to each statement by marking one answer per row.

	Never	Rarely	Sometimes	Usually	Always
I feel left out.	○	○	○	○	○
I feel that people barely know me.	○	○	○	○	○
I feel isolated from others.	○	○	○	○	○
I feel that people are around me but not with me.	○	○	○	○	○

End of Block: PROMIS Social Isolation

Start of Block: DUREL- Duke University Religion Index

How often do 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

How often do you spend time in private religious activities, such as prayer, meditation or bible study?

- ○ Never
- ○ Once a year
- ○ A few times a year
- ○ A few times a month
- ○ Once a week
- ○ More than once a week

The following section contains three statements about religious beliefs of experience. Please mark the extent to which each statement is true or not true for you.

In my life I experience the presence of the Divine (i.e., God)

- ○ Definitely *not* true
- ○ Tends not to be true
- ○ Unsure
- ○ Tends to be true
- ○ Definitely true of me

My religious beliefs are what really lie behind my whole approach to life.

- ○ Definitely *not* true
- ○ Tends not to be true
- ○ Unsure
- ○ Tends to be true
- ○ Definitely true of me

I try hard to carry my religion over into all other dealings in life.

- ○ Definitely *not* true
- ○ Tends not to be true
- ○ Unsure
- ○ Tends to be true
- ○ Definitely true of me

End of Block: DUREL- Duke University Religion Index

Start of Block: Cancer Treatment

The next few items ask about treatment for your ${e://Field/CancerSite} cancer and other cancer diagnoses.

In the past year have you had surgery for your ${e://Field/CancerSite} cancer?

- ○ Yes
- ○ No

In the past year have you had chemotherapy for your cancer (oral or IV)?

- ○ Yes
- ○ No

In the past year have you had radiation for your ${e://Field/CancerSite} cancer?

- ○ Yes
- ○ No

In the past year have you received hormone therapy (in any form) to treat your ${e://Field/CancerSite} cancer?

- ○ Yes
- ○ No

In the past year did you complete treatment for your initial diagnosis of ${e://Field/CancerSite} cancer?

- ○ Yes
- ○ No
- ○ Still in Treatment
- ○ Completed treatment more than 1 year ago

In the past year have you been diagnosed with another cancer other than ${e://Field/CancerSite} cancer?

- ○ Yes
- ○ No

Please indicate the type(s) of newly diagnosed cancer (e.g. bladder cancer) and approximate month and year of diagnosis.

	Cancer Type	Month of diagnosis	Year of diagnosis
	(ex: bladder cancer)	(ex: May = 05)	(ex: 2014)
Cancer diagnosis 1			
Cancer diagnosis 2			
Cancer diagnosis 3			

End of Block: Cancer Treatment

Start of Block: Surveillance

Please indicate if you have ever had this type of test or screening in the past 12 months.

	Have you had in the past 12 months?	
	Yes	No
Mammogram	○	○
Pap Smear	○	○
Pelvic Exam	○	○
Fecal Occult Blood Test	○	○
Sigmoidoscopy	○	○
Colonoscopy	○	○
Virtual Colonoscopy	○	○
CT scan (computerized tomography or CAT scan (computerized axial tomography)	○	○
Physical examination	○	○
Biopsy of any kind (Please describe):	○	○

Please indicate if you have had this type of test or screening in the past 12 months.

	Have you had in the past 12 months?	
	Yes	No
PSA (Prostate Specific Antigen)	○	○
DRE (Digital Rectal Exam)	○	○
Fecal Occult Blood Test	○	○
Sigmoidoscopy	○	○
Colonoscopy	○	○
Virtual Colonoscopy	○	○
CT scan (computerized tomography or CAT scan (computerized axial tomography)	○	○
Physical examination	○	○
Biopsy of any kind (Please describe):	○	○

End of Block: Surveillance

Start of Block: Treatment Summary & Follow-up Care Plan

In this section, we will ask you information about follow-up care you may or may not have received from your oncologists or anyone on your cancer treatment team. Even though you may have received the information from another source, please only answer in terms of your treating oncologists or members of your treatment team.

At the completion of your cancer treatment, did you receive a **written summary** from your doctor(s) that included details of the treatment you had received and provided other important details regarding your cancer care? (It may have been referred to as a treatment summary, or something similar to that).

- ○ Yes
- ○ No
- ○ Don't know/not sure
- ○ Still in Treatment

At what point did you receive this summary?

- ○ Before completing treatment
- ○ On the last day of treatment
- ○ Within one month after completing treatment
- ○ 1-3 months after completing treatment
- ○ 3-6 months after completing treatment
- ○ 6-12 months after completing treatment
- ○ More than 12 months after completing treatment

Have you ever gone back to review that summary?

- ○ Yes
- ○ No

At the completion of your cancer treatment, did you receive a written follow-up plan from your doctor(s) that discussed things you should consider for the future, such as what type of follow-up care and testing you should receive and when; or information about legal, financial, psychological, and social issues and services? (It may have been referred to as a treatment summary or something similar).

- ○ Yes
- ○ No
- ○ Don't know/not sure

Have you ever gone back to review that treatment summary?

- Yes
- No

At what point after the end of your treatment did you receive this treatment summary?

- Before completing treatment
- On the last day of treatment
- Within one month after completing treatment
- 1-3 months after completing treatment
- 3-6 months after completing treatment
- 6-12 months after completing treatment
- More than 12 months after completing treatment

End of Block: Treatment Summary & Follow-up Care Plan

Start of Block: Financial/ Household Demographics

What was your household income last year (before taxes)?

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

Did your income go down since your cancer diagnosis? If so, by how much?

- ○ Income did not change
- ○ 1% to 10% decrease
- ○ 11% to 20% decrease
- ○ 21% to 30% decrease
- ○ 31% to 50% decrease
- ○ More than 50% decrease
- ○ Other (Please specify): _____

How many children under age 18 live in your household?

_____

How many adults (ages 18 and older) currently live in your household? Please include yourself.

_____

How long have you lived at your current address?

- ○ Years _____
- ○ Months _____

End of Block: Financial/ Household Demographics

Start of Block: Financial Hardship & Access to Medical Care

Some cancer survivors have faced changes to their health insurance status and financial well-being after cancer diagnosis.

The following questions ask about your health insurance coverage and about the financial impact of your cancer diagnosis.

What kind of health insurance do you currently have? Please select all that apply.

- [ ] Medicare
- [ ] Medicaid
- [ ] Private insurance through my or my partner's employer
- [ ] Private insurance that I purchased on my own (not through an employer)
- [ ] VA
- [ ] I do not have insurance
- [ ] Other (Please specify): _____

Where do you typically go for your own health care?

- ○ Primary Care Doctor
- ○ Specialist
- ○ Emergency Room
- ○ Walk-in/Ambulatory Clinic
- ○ Don't know

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

- ○ Yes
- ○ No

In order to pay bills related to your 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 stocks or other investments
- [ ] Withdraw money from retirement savings
- [ ] Withdraw money from savings accounts
- [ ] Other (Please specify): _____
- [ ] None of the above

Have you or any member of your household had to borrow money from other friends or family members to help pay for your cancer treatment?

- ○ Yes
- ○ No

Are you currently in debt due to expenses related to your cancer treatment?

- ○ Yes
- ○ No

Did you ever turn down treatments (chemotherapy, radiation, pain medications, anti-nausea medications, anti-diarrhea medications, or other recommended cancer treatments) because you were concerned about the cost?

- ○ Yes
- ○ No

Did you ever skip doses of prescribed medication in order to save money?

- ○ Yes
- ○ No

End of Block: Financial Hardship & Access to Medical Care

Start of Block: COST- Patient Reported Outcomes Measures of Financial Toxicity

Below are lists about financial concerns that other cancer survivors have said are important.
Please mark one response per line as it applies to you over the past 7 days.

	Not at all	A little bit	Somewhat	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	○	○	○	○	○

End of Block: COST- Patient Reported Outcomes Measures of Financial Toxicity

Start of Block: Wrap Up

Please share any feedback about the survey or additional information you feel is important in the box below.

_____

_____

_____

_____

_____

Thank you for completing the survey!

Please select which one $25.00 gift card you would like to receive as a thank you for your time.

- ○ CVS
- ○ Meijer
- ○ Target

Please enter your preferred contact information and the mailing address where you would like the gift card sent. If available, please also include the best email address and number(s) on which to reach you, in case there is a problem with the gift card delivery. Future correspondence will also be mailed to this address.

- ○ Address _____
- ○ Address 2 _____
- ○ City _____
- ○ State _____
- ○ Postal Code _____

	Click to enter phone number	Type			
	Number	Home	Cell	Work	Other
Phone Number:		○	○	○	○
Alternative Phone Number:		○	○	○	○

Email Address

_____

Do you consent to future contact for additional studies on cancer survivors? By agreeing to this item you still have the option to not participate in the future studies presented to you.

- ○ Yes
- ○ No

The survey is complete. Your gift card will be mailed to you within 1-2 weeks.

Please remember to sign and mail back the consent form you received in the pre-paid envelope that was provided. If you need another consent form, have questions or need to update your contact information at any time please contact the research team at 1-844-729-4854.

Thank you!

End of Block: Wrap Up