



Research on Cancer Survivors

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

Cancer Survivor
Follow Up Survey
Year 5

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Version: 2

Revised: 10/27/22

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 30-44 minutes
 10-19 minutes 45-59 minutes
 20-29 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 30-44 minutes
 10-19 minutes 45-59 minutes
 20-29 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

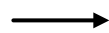
In the past 4 weeks, how often did you ...	Never, or less than once per week	1-3 times per week	4-6 times per week	Once per day	More than once per day
4.3 eat processed meat, such as ham, bologna, salami, hot dogs, bacon or sausage?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.4 eat other red meat, such as steak, hamburger, pork or lamb, alone or in other dishes such as sandwiches, pasta or pizza?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.6 eat fast food such as McDonald's, KFC or Taco Bell?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4.7 eat sweets or desserts such a cookies, cake, pie or ice cream?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Woke up in the middle of the night or early morning	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Had to use the bathroom	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Could not breathe comfortably	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Coughed or snored loudly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Felt too cold	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Felt too hot	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Had bad dreams	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Heard noises	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Had pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Have pets	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. Other reason(s); Please describe: _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m. During the past week , how often did you take medicine (prescribed or "over the counter") to help you sleep?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
n. During the past week , how often did you have trouble staying awake while eating meals, or engaging in social activity?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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: FAMILY HISTORY OF CANCER

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

8.1 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 8.2** No → **Go To Section 9**
 Don't know →

8.2 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			
_____	<input type="radio"/>	<input type="radio"/>	_____	_____	_____
_____	<input type="radio"/>	<input type="radio"/>	_____	_____	_____
_____	<input type="radio"/>	<input type="radio"/>	_____	_____	_____
_____	<input type="radio"/>	<input type="radio"/>	_____	_____	_____
_____	<input type="radio"/>	<input type="radio"/>	_____	_____	_____
_____	<input type="radio"/>	<input type="radio"/>	_____	_____	_____
_____	<input type="radio"/>	<input type="radio"/>	_____	_____	_____

SECTION 9: MEDICAL HISTORY

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

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

9.2 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? <input type="radio"/> Rheumatoid <input type="radio"/> Osteoarthritis <input type="radio"/> Unsure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
2. Emphysema	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
3. COPD (chronic obstructive pulmonary disease)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
4. Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
5. Diabetes ↳ What kind? <input type="radio"/> Type I <input type="radio"/> Type II <input type="radio"/> Gestational <input type="radio"/> Unsure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
6. Fracture (broken bone), over age 50 ↳ Part of body? _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
7. Heart Problems ↳ What kind? <input type="radio"/> Heart Attack <input type="radio"/> Congestive Heart Failure <input type="radio"/> Afib (Atrial fibrillation) <input type="radio"/> Coronary artery disease <input type="radio"/> Other <input type="radio"/> Unsure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
8. Hepatitis (any type)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
9. High cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
10. Hypertension (high blood pressure)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
11. Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
12. Thyroid problem	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>
13. Any other medical condition <i>not previously listed</i> ↳ Name of other medical condition(s)? _____	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____	<input type="radio"/>	<input type="radio"/>

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.

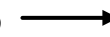
9.3 Are you **currently** taking any *prescription* medications?

Yes



Complete table below

No



Go To Question 9.4

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
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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.)

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

- Yes → **Go To Question 9.5**

 No → **Go To Section 10**

9.5 For how long did you take hormone therapy?

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

9.6 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: _____

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

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

SECTION 10: VITAMINS AND PAIN MEDICATIONS

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

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

- Yes No

10.2 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?		For how many months in the past year have you taken this medication?
		3 days per week or less	4 days per week or more	
Acetaminophen (such as Tylenol or Aspirin-free Excedrin)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Aspirin (such as Anacin, Bufferin, Alka-Seltzer, Bayer, or Excedrin, or baby/ low-dose aspirin)				
Full Strength Aspirin (325 mg)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Baby Aspirin (81 mg)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Ibuprofen (such as Advil, Motrin, Nuprin, or Mediprin)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Naproxen (such as Aleve, Naprosyn, Anaprox, or Naprelan)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____
Other over-the-counter pain relievers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	_____

SECTION 11: CANCER TREATMENT

The next few items ask about treatment for cancer.

11.1 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 11.2**

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

11.2 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 11.4**

11.3 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 11.4**

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

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

Yes →

Type of Cancer	Age at Diagnosis

 No → **Go To Question 11.6**

Type of Cancer	Age at Diagnosis

11.5 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 11.6**

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

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

Yes → **Go To Question 11.7a** No → **Go To Section 12**

11.7a Since receiving chemotherapy have you experienced numbness, pain or tingling in your hands or feet?

Yes, currently } **Go To Question 11.7b** No, never → **Go To Question 11.7e**
 Yes, formerly }

11.7b 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.

11.7c Had you experienced these symptoms prior to your chemotherapy treatment? (Select all that apply)

Yes, numbness } **Go To Question 11.7d** No → **Go To Question 11.7e**
 Yes, pain }
 Yes, tingling }

11.7d Has the numbness, pain, or tingling in your hands or feet worsened with chemotherapy treatment?

Yes No

11.7e Since receiving chemotherapy have you ever experienced weakness in your arms or legs?

Yes, currently } **Go To Question 11.7f** No, never → **Go To Question 11.7i**
 Yes, formerly }

11.7f 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.

- 11.7g Had you experienced these symptoms prior to your chemotherapy treatment?
 Yes → **Go To Question 11.7h** No → **Go To Question 11.7i**
- 11.7h Has the weakness in your arms or legs worsened with chemotherapy treatment?
 Yes No
- 11.7i 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
 - Performing other activities of importance to me (please specify) _____
 - None of the above** / not applicable
 - Walking
 - Buttoning clothes or fastening buckles
 - Tying shoes
 - Using a telephone
 - Climbing stairs
 - Sewing
 - Operating a remote control
 - Knitting

SECTION 12: CANCER SCREENING

12.1 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
COLORECTAL CANCER SCREENING TESTS:			
Colonoscopy (entire colon) or sigmoidoscopy (lower colon only)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fecal occult blood test (FOBT – looks for blood in feces)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
BREAST CANCER SCREENING TESTS: (FOR WOMEN)			
Mammogram	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clinical breast exam (a breast exam performed by a health care provider)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
CERVICAL CANCER SCREENING TESTS: (FOR WOMEN)			
Pap smear (a swab of the cervix)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PROSTATE CANCER SCREENING TESTS: (FOR MEN)			
Prostate Specific Antigen test (PSA – blood test)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Digital Rectal Exam (DRE – doctor checks prostate by inserting a finger into the rectum)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

- 12.2 Have you ever been referred for genetic testing by a physician?
 Yes No Don't know / not applicable
- 12.3 Have you ever undergone genetic testing?
 Yes No Don't know / not applicable
- 12.3 Have you ever met with a genetic counselor?
 Yes No Don't know / not applicable

Section 13: COVID-19

- 13.1. Have you ever tested positive for COVID-19?
 Yes → **Go to Question 13.2** No → **Go to Question 13.3**
 Not sure → **Go to Question 13.3**
- 13.2. 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
- 13.3. Have you received at least one dose of a COVID-19 vaccine?
 Yes No
- 13.4. Did you receive (or do you plan to receive) all required doses?
 Yes, received all required doses → **Go to Question 13.5**
 No, but plan to receive all required doses → **Go to Question 13.6**
 No, don't plan to receive all required doses → **Go to Question 13.6**
- 13.5. Did you receive (or do you plan to receive) a booster shot?
 Yes, received the booster → **Go to Section 14**
 No, but plan to receive the booster → **Go to Question 13.6**
 No, don't plan to receive the booster → **Go to Question 13.6**
- 13.6. 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 14: 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have nausea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Because of my physical condition, I have trouble meeting the needs of my family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am bothered by side effects of treatment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel ill	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am forced to spend time in bed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SOCIAL/FAMILY WELL-BEING					
I feel close to my friends	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I get emotional support from my family	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I get support from my friends	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My family has accepted my illness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am satisfied with family communication about my illness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel close to my partner (or the person who is my main support)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<i>Regardless of your current level of sexual activity, please answer the following question. If you prefer not to answer it, please mark this box <input type="checkbox"/> and go to the next question.</i>					
I am satisfied with my sex life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
EMOTIONAL WELL-BEING					
I feel sad	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am satisfied with how I am coping with my illness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am losing hope in the fight against my illness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel nervous	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I worry about dying	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I worry that my condition will get worse	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
FUNCTIONAL WELL-BEING					
I am able to work (include work at home)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My work (include work at home) is fulfilling	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am able to enjoy life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have accepted my illness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am sleeping well	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am enjoying the things I usually do for fun	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am content with the quality of my life right now	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

SECTION 15: 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My thinking has been slow	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have had trouble concentrating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have had trouble finding my way to a familiar place	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have had trouble remembering where I put things, like my keys or my wallet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have had trouble remembering new information, like phone numbers or simple instructions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have had trouble recalling the name of an object while talking to someone	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have had trouble finding the right word(s) to express myself	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have used the wrong word when I referred to an object	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have had trouble saying what I mean in conversations with others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have walked into a room and forgotten what I meant to get or do there	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have had to work really hard to pay attention or I would make a mistake	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have forgotten names of people soon after being introduced	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My reactions in everyday situations have been slow	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have had to work harder than usual to keep track of what I was doing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My thinking has been slower than usual	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have had to work harder than usual to express myself clearly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have had to use written lists more often than usual so I would not forget things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have trouble keeping track of what I am doing if I am interrupted	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have trouble shifting back and forth between different activities that require thinking	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

SECTION 16: 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel weak all over	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel listless (“washed out”)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel tired	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have trouble <u>starting</u> things because I am tired	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have trouble <u>finishing</u> things because I am tired	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have energy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am able to do my usual activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I need to sleep during the day	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am too tired to eat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I need help doing my activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am frustrated by being too tired to do the things I want to do	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have to limit my social activity because I am tired	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

SECTION 17: 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I found it hard to focus on anything other than my anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My worries overwhelmed me	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt uneasy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt worthless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt helpless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt depressed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt hopeless	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

SECTION 18: MEDICAL BELIEFS

These questions ask about your beliefs about the care you and other people of your racial and ethnic group receive from doctors, nurses, and other staff people in the health care system. Please indicate how much you agree or disagree with the following statements.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree	Prefer Not to Answer
Doctors and health care workers sometimes hide information from patients who belong to my racial / ethnic group.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Doctors have the best interests of people of my racial / ethnic group in mind.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
People of my racial / ethnic group should not confide in doctors and health care workers because it will be used against them.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
People of my racial / ethnic group should be suspicious of information from doctors and health care workers.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
People of my racial / ethnic group cannot trust doctors and health care workers.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
People of my racial / ethnic group should be suspicious of modern medicine.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Doctors and health care workers treat people of my racial / ethnic group like "guinea pigs".	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
People of my racial / ethnic group receive the same medical care from doctors and health care workers as people from other groups.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Doctors and health care workers do not take the medical complaints of people of my racial / ethnic group seriously.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
People of my racial / ethnic group are treated the same as people of other groups by doctors and health care workers.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In most hospitals, people of different racial / ethnic groups receive the same kind of care.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have personally been treated poorly or unfairly by doctors or health care workers because of my race / ethnicity.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

SECTION 19: PERSONAL STRESS

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

19.1. 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 unexpectedly	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have felt unable to control the important things in my life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have felt nervous and stressed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have felt confident about my ability to handle my personal problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have felt things were going my way	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have found that I could not cope with all the things I had to do	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have been able to control irritations in my life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have felt on top of things	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I have been angered because of things that happened that were outside of my control	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I felt difficulties were piling up so high that I could not overcome them	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

SECTION 20: FINANCIAL CONCERNS

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

20.1 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

20.2 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

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

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

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

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

- Yes → **Go To Question 20.6**
- No → **Go To Question 20.7**

20.6 How long have you lived at your current address?

- Less than 6 months
- 6 months - 1 year

20.7 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.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am satisfied with my current financial situation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I worry about the financial problems I will have in the future as a result of my illness or treatment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am frustrated that I cannot work or contribute as much as I usually do.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My cancer or treatment has reduced my satisfaction with my present financial situation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel in control of my financial situation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am able to meet my monthly expenses.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I know that I have enough money in savings, retirement, or assets to cover the costs of my treatment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am concerned about keeping my job and income, including working at home.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I feel I have no choice about the amount of money I spend on care.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My out-of-pocket medical expenses are more than I thought they would be.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

20.8 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

SECTION 21: SOCIAL NEEDS

- 21.1 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
- 21.2 In the **last 12 months**, has a utility company shut off your service for not paying your bills?
 Yes No
- 21.3 Are you worried that in the **next 2 months** you may not have stable housing?
 Yes No
- 21.4 In the **last 12 months**, have you ever had to go without health care because you didn't have transportation?
 Yes No
- 21.5 Generally, do you feel safe in your neighborhood?
 Yes No
- 21.6 In the **last 12 months**, have you skipped doses of prescribed medication to save money?
 Yes No

SECTION 22: CAREGIVING RESPONSIBILITIES

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

- Yes → **Go To Question 22.2** No → **Go To Section 23**

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

I am his/her:

- | | |
|---|--|
| <input type="radio"/> Child | <input type="radio"/> Friend |
| <input type="radio"/> Grandchild | <input type="radio"/> Other individual |
| <input type="radio"/> Parent | (please specify) _____ |
| <input type="radio"/> Grandparent | |
| <input type="radio"/> Other family member | |
| (please specify) _____ | |

22.3 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 23: RELIGION

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

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

- | | |
|---|---|
| <input type="radio"/> Never | <input type="radio"/> Once a week |
| <input type="radio"/> Once a year | <input type="radio"/> More than once a week |
| <input type="radio"/> A few times a year | |
| <input type="radio"/> A few times a month | <input type="radio"/> Not answered / not applicable |

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

- | | |
|--|---|
| <input type="radio"/> Rarely or never | <input type="radio"/> Daily |
| <input type="radio"/> A few times a month | <input type="radio"/> More than once a day |
| <input type="radio"/> Once a week | |
| <input type="radio"/> Two or more times a week | <input type="radio"/> Not answered / not applicable |

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

Cancer Survivor Follow Up Survey Year 5 STUDY ID#:

Version: 2

Revised: 10/27/2022

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

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.

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