Research on Cancer Survivors

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

Cancer Survivor Survey
Version: 4
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SECTION 1: DEMOGRAPHICS / BACKGROUND INFORMATION

Thank you for being 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.

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)

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

- ❍ Homemaker
- ❍ Unemployed
- ❍ Retired
- ❍ On Disability
- ❍ Other: (please specify): _____

1.2 What was your employment status **prior to your cancer diagnosis**?

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

1.3 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): _____

1.4 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): _____

1.5 Is this the same health insurance you had at the time of your cancer diagnosis?

❍ Yes → **Go To Question 1.7** ❍ No → **Go To Question 1.6**

1.6 What kind of health insurance did you have at the time of your cancer diagnosis? (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 did not have insurance
- ❍ Other: (please specify): _____

1.7 What is the month and year of your birth?(For example, if you were born in August of 1970 you would enter: 08 1970)

Month _____
Year _____

1.8 With which race do you most closely identify (Select all that apply)?

- ❍ Caucasian or White
- ❍ African American or Black
- ❍ Asian
- ❍ Native Hawaiian or Other Pacific Islander
- ❍ American Indian or Alaska Native
- ❍ Other (please specify) _____

1.9 What is the highest grade of school that you completed?

- ❍ Less than high school
- ❍ High school/ GED
- ❍ Some college
- ❍ 2-year degree
- ❍ 4-year degree
- ❍ Graduate/ Professional degree

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

- ❍ Married
- ❍ Living as married
- ❍ Widowed
- ❍ Separated
- ❍ Divorced
- ❍ Never married

SECTION 2: DOWN TIME

The next sections will ask about your health behaviors.

2.1 On average, in the **12 months before you were diagnosed** with cancer, 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 **12 months before you were diagnosed** with cancer, how many hours each day did you spend sitting at work?

❍ Less than 1 ❍ 1-2 ❍ 3-4 ❍ 5 or more ❍ not applicable

2.3 On average, in the **12 months before you were diagnosed** with cancer, how many hours each day did you spend sleeping or lying down?

❍ Less than 5 hours ❍ 5-6 hours ❍ 7-8 hours ❍ More than 8 hours

SECTION 3: 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 Question 3.8**

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

❍ Yes ❍ No → **Go To Question 3.5**

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

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

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

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

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

❍ Yes ❍ No → **Go To Question 3.8**

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

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

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

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

3.8 Is this your usual pattern of physical activity?

❍ Yes ❍ No

3.9 Is this typical of your pre-diagnosis physical activity?

❍ Yes ❍ No

SECTION 4: DIET

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

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

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

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

In the **past 4 weeks,** how often did you …	Never, or less than once per week	1-3 times per week	4-6 times per week	Once per day	More than once per day
4.3. eat processed meat, such as ham, bologna, salami, hot dogs, bacon or sausage?	❍	❍	❍	❍	❍
4.4. eat other red meat, such as steak, hamburger, pork or lamb, alone or in other dishes such as sandwiches, pasta or pizza?	❍	❍	❍	❍	❍
4.5 have a serving of regular soda or pop that contains sugar? (A serving is the same as a 12-oz can of soda). **Do not include diet soda**.	❍	❍	❍	❍	❍
4.6 eat fast food such as McDonald's, KFC or Taco Bell?	❍	❍	❍	❍	❍
4.7 eat sweets or desserts such a cookies, cake, pie or ice cream?	❍	❍	❍	❍	❍

In the **past 4 weeks**…	None, or less than 1	1-3	4-6	7-9	10 or more
4.8 how many glasses of water did you drink each day? (A glass is equal to 8 ounces)	❍	❍	❍	❍	❍

SECTION 5: TOBACCO USE

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 Have you smoked at least 100 cigarettes in your life?

❍ Yes → **Go To Question 5.2** ❍ No → **Go To Question 5.9**

5.2 How old were you when you first started smoking cigarettes **on a regular basis**?
(Regular is defined as at least one cigarette a day for 1 month or more)

Age in years _____ OR ❍ I never smoked on a regular basis

5.3 Did you smoke cigarettes at the time you were first diagnosed with cancer?

❍ Yes, I smoked daily
❍ Yes, I smoked some days
❍ No, I did not smoke at the time of my cancer diagnosis

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

❍ Yes → **Go To Question 5.6** ❍ No → **Go To Question 5.5**

5.5 How old were you when you last smoked cigarettes on a regular basis (at least one cigarette a day for 1 month or more)?

Age in years: _____ **OR** Year Quit: _____

5.6 **Over the entire time** you smoked cigarettes (on a regular basis), how many cigarettes do *I* 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

5.7 During the **entire time** you/ you've smoked, was there any time where you quit ***for 1 year or more***?

❍ Yes → **Go To Question 5.8** ❍ No → **Go To Question 5.9**

↳ 5.8 During the **entire** time you/you've smoked, for how many **total** years did you quit smoking? Years _____

5.9 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

5.10 Have you **ever** vaped or smoked electronic cigarettes (e-cigarettes)?

❍ Yes → **Go To Question 5.11** ❍ No → **Go To Question 6.1**

5.11 Do you **currently** vape or smoke e-cigarette

❍ Yes ❍ No

SECTION 6: ALCOHOL USE

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

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

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

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

Number per week

_____ Glasses of wine (5 oz)

_____ Cans or bottles of beer (12 oz)

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

_____ Malt liquor (8 oz)

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

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

SECTION S: SLEEP SUPPLEMENT

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

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

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

❍ Yes ❍ No

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

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

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

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

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

Time: _____ am/ pm

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

Minutes to fall asleep: _____

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

Time: _____ am/ pm

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

Hours of sleep each night: _____

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

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

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

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

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

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

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

❍ Yes ❍ No

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

❍ Yes ❍ No

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

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

SECTION 7: FAMILY HISTORY OF CANCER

Next, we would like to know a little about your biological family and about their history of cancer.

7.1 How many full (share both biological mother and biological father) biological sisters do you have? (Please include both living and deceased sisters. Please do not include half-, step-, or adopted sisters)

_____

7.2 How many full (share both biological mother and biological father) biological brothers do you have? (Please include both living and deceased brothers. Please do not include half-, step-, or adopted brothers)

_____

7.3 How many biological daughters do you have? _____

7.4 How many biological sons do you have? _____

7.5 Please let us know if any of the following biological relatives have been diagnosed with cancer: mother, grandmothers, sisters, and/or daughters. *For any relative below who was ever diagnosed with cancer*, please note **whether she is still living**, the **type of cancer** with which she was diagnosed, and the **age at diagnosis**. If you are unsure of the cancer type, please write "unknown". If you are unsure of her age at diagnosis, please give your best estimate. (Please do **not** include adoptive or step mother, half-, step-, or adopted sisters, or adoptive or step daughters for this item).

	Ever Diagnosed with Cancer?			Still Living?		Type of Cancer(s)	Age at Diagnosis
	Yes	No	Don't Know	Yes	No		
Mother	❍	❍	❍	❍	❍	_____	_____
Maternal Grandmother (your mother's mother)	❍	❍	❍	❍	❍	_____	_____
Paternal Grandmother (your father's mother)	❍	❍	❍	❍	❍	_____	_____
Full Biological Sisters:							
Sister #1 with cancer	❍	❍	❍	❍	❍	_____	_____
Sister #2 with cancer	❍	❍	❍	❍	❍	_____	_____
Sister #3 with cancer	❍	❍	❍	❍	❍	_____	_____
Biological Daughters:							
Daughter #1 with cancer	❍	❍	❍	❍	❍	_____	_____
Daughter #2 with cancer	❍	❍	❍	❍	❍	_____	_____
Daughter #3 with cancer	❍	❍	❍	❍	❍	_____	_____

7.6 Please let us know if any of the following biological relatives have been diagnosed with cancer: father, grandfathers, brothers, and/ or sons. *For any relative below who was ever diagnosed with cancer*, please note **whether he is still living**, the **type of cancer** with which he was diagnosed, and the **age at diagnosis**. If you are unsure of the cancer type, please write "unknown". If you are unsure of his age at diagnosis, please give your best estimate.
(Please do **not** include adoptive or step father, half-, step-, or adopted brothers, or adoptive or step sons for this item).

	Ever Diagnosed with Cancer?			Still Living?		Type of Cancer(s)	Age at Diagnosis
	Yes	No	Don't Know	Yes	No		
Father	❍	❍	❍	❍	❍	_____	_____
Maternal Grandfather (your mother's father)	❍	❍	❍	❍	❍	_____	_____
Paternal Grandfather (your father's father)	❍	❍	❍	❍	❍	_____	_____
Full Biological Brothers:							
Brother #1 with cancer	❍	❍	❍	❍	❍	_____	_____
Brother #2 with cancer	❍	❍	❍	❍	❍	_____	_____
Brother #3 with cancer	❍	❍	❍	❍	❍	_____	_____
Biological Sons:							
Son #1 with cancer	❍	❍	❍	❍	❍	_____	_____
Son #2 with cancer	❍	❍	❍	❍	❍	_____	_____
Son #3 with cancer	❍	❍	❍	❍	❍	_____	_____

SECTION 8: MEDICAL HISTORY

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

8.1 What is your **current** height? Feet _____ Inches _____

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

8.3 What was your approximate weight **one year before** being diagnosed with cancer?
_____ pounds

8.4 Has a doctor **ever** told you that you have any of the following medical conditions? [Please check all that apply, give your approximate age at diagnosis, and whether you are currently being treated.]

Medical Condition	Ever Diagnosed? Yes	No	Unsure	Age at Diagnosis	Currently Being Treated? Yes	No
1. Arthritis	❍	❍	❍	_____	❍	❍
↳ What kind? ❍ Rheumatoid ❍ Osteoarthritis ❍ Unsure						
2. Emphysema	❍	❍	❍	_____	❍	❍
3. COPD (chronic obstructive pulmonary disease)	❍	❍	❍	_____	❍	❍
4. Depression	❍	❍	❍	_____	❍	❍
5. Diabetes	❍	❍	❍	_____	❍	❍
↳ What kind? ❍ Type I ❍ Type II ❍ Unsure						
6. Fracture (broken bone), over age 50	❍	❍	❍	_____	❍	❍
↳ Part of body? _____						
7. Heart Problems	❍	❍	❍	_____	❍	❍
↳ What kind? ❍ Heart Attack ❍ Congestive Heart Failure ❍ Afib (Atrial fibrillation) ❍ Coronary artery disease ❍ Other ❍ Unsure						
8. Hepatitis (any type)	❍	❍	❍	_____	❍	❍
9. High cholesterol	❍	❍	❍	_____	❍	❍
10. Hypertension (high blood pressure)	❍	❍	❍	_____	❍	❍
11. Stroke	❍	❍	❍	_____	❍	❍
12. Thyroid problem	❍	❍	❍	_____	❍	❍

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

❍No ❍ Yes ⟶

Type of Cancer	Age at Diagnosis

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

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

❍ Yes ⟶ **Complete table below** ❍ No ⟶ **Go To Question 8.7**

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

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

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

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

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

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

❍ Yes ⟶ **Go To Question 8.8** ❍ No ⟶ **Go To Section 9**

8.8 For how long did you take hormone therapy?

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

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

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

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

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

SECTION 9: VITAMINS AND PAIN MEDICATIONS

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

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

❍ Yes ❍ No

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

❍ Yes ❍ No

9.3 In the **past year**, have you taken any of the following **at least once a week for at least one month**?

Medication	Taken 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?
	Yes	No	**3 days** per week or less	**4 days** per week or more	
Acetaminophen (such as Tylenol or Aspirin-free Excedrin)	❍	❍	❍	❍	_____
Aspirin (such as Anacin, Bufferin, Alka-Seltzer, Bayer, or Excedrin, or baby/ low-dose aspirin)					
Full Strength Aspirin (325 mg)	❍	❍	❍	❍	_____
Baby Aspirin (81 mg)	❍	❍	❍	❍	_____
Ibuprofen (such as Advil, Motrin, Nuprin, or Mediprin)	❍	❍	❍	❍	_____
Naproxen (such as Aleve, Naprosyn, Anaprox, or Naprelan)	❍	❍	❍	❍	_____
Other over-the-counter pain relievers	❍	❍	❍	❍	_____

SECTION 10: CANCER TREATMENT

The next few items ask about treatment for your cancer.

10.1 At which institution(s) did you receive your cancer diagnosis and / or treatment? (Select all that apply).

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

10.2 Have you received treatment or surgery for your cancer?

❍ Yes → **Go To Question 10.3** ❍ No → **Go To Section 11**

10.3 Did you complete treatment for your initial cancer diagnosis?

Please **do not** count long-term hormone therapy (such as Tamoxifen, aromatase inhibitors, Lupron, or Casodex) that some survivors take for several years after completing other cancer treatment.

❍ Yes, I have completed treatment → **Go To Question 10.4**

❍ No, I am still undergoing treatment → **Go To Question 10.5**

10.4 On what month and year did you complete treatment? Month _____ Year _____

10.5 Have you ever had surgery for your cancer? ❍ Yes ❍ No

10.6 Have you ever had radiation for your cancer? ❍ Yes ❍ No

10.7 Have you ever received hormone therapy (in any form) to treat your cancer?

❍ Yes ❍ No

10.8 Have you ever received immunotherapy to treat your cancer?

❍ Yes ❍ No

10.9 Have you ever had chemotherapy for your cancer (oral or IV)?

❍ Yes → **Go To Question 10.9a** ❍ No → **Go To Section 11**

10.9a Since receiving chemotherapy have you ever experienced numbness, pain or tingling in your hands or feet?

❍ Yes, currently
❍ Yes, formerly
→ **Go To Question 10.9b**

❍ No, never → **Go To Question 10.9e**

10.9b Please choose the statement that best describes the numbness, pain or tingling in your hands or feet:

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

10.9c Had you experienced these symptoms prior to your chemotherapy treatment? (select all that apply)

❍ Yes, numbness ❍ Yes, pain ❍ Yes, tingling ❍ No

10.9d Has the numbness, pain, or tingling in your hands or feet worsened with chemotherapy treatment?

❍ Yes ❍ No

10.9e Since receiving chemotherapy have you ever experienced weakness in your arms or legs?

❍ Yes, currently
❍ Yes, formerly

Go To Question 10.9f

❍ No, never → **Go To Question 10.9i**

10.9f Please choose the statement that best describes the weakness in your arms or legs:

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

10.9g Had you experienced these symptoms prior to your chemotherapy treatment?

❍ Yes ❍ No

10.9h Has the weakness in your arms or legs worsened with chemotherapy treatment?

❍ Yes ❍ No

10.9i 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
- ❍ Knitting
- ❍ Walking
- ❍ Buttoning clothes or fastening buckles
- ❍ Tying shoes
- ❍ Using a telephone
- ❍ Climbing stairs
- ❍ Sewing
- ❍ Operating a remote control
- ❍ Driving
- ❍ Performing other activities of importance to me (please specify) _____
- ❍ **None of the above** / not applicable

SECTION 11: CANCER SURVEILLANCE

Have you **ever** had any of the following cancer screening tests?

Type of screening test:	Ever had this type of test?			When did you receive your most recent test?				
	Yes	No	I don't know	Less than 1 year ago	1-2 years ago	3-5 years ago	6-10 years ago	More than 10 years
Colorectal Cancer Screening:								
Colonoscopy (entire colon) or sigmoidoscopy (lower colon only)	❍	❍	❍	❍	❍	❍	❍	❍
Fecal occult blood test (FOBT – looks for blood in feces)	❍	❍	❍	❍	❍	❍	❍	❍
Lung Cancer Screening:								
Screening CT scan of the lungs	❍	❍	❍	❍	❍	❍	❍	❍
Prostate Cancer Screening: (FOR MEN)								
Prostate Specific Antigen test (PSA – blood test)	❍	❍	❍	❍	❍	❍	❍	❍
Digital Rectal Exam (DRE – doctor checks prostate by inserting a finger into the rectum)	❍	❍	❍	❍	❍	❍	❍	❍
Breast Cancer Screening: (FOR WOMEN)								
Mammogram	❍	❍	❍	❍	❍	❍	❍	❍
Clinical breast exam (a breast exam performed by a health care provider)	❍	❍	❍	❍	❍	❍	❍	❍
Cervical Cancer Screening: (FOR WOMEN)								
Pap smear (a swab of the cervix)	❍	❍	❍	❍	❍	❍	❍	❍

SECTION 12: HEALTH LITERACY

The following questions ask about your confidence in completing medical forms and your use of the Internet, smartphones, and other technology in relation to health and healthcare.

12.1 How confident are you filling out medical forms by yourself?

- ❍ Extremely
- ❍ Quite a bit
- ❍ Somewhat
- ❍ A little bit
- ❍ Not at all

12.2 Do you own and/or have regular access to a desktop computer, laptop computer, tablet or smartphone?

- ❍ Yes
- ❍ No

12.3 Have you ever gone online to find health-related information related to your illness or treatment? (This could include searching for information about a health condition or disease, specific symptoms, or about medical treatments or procedures)

- ❍ Yes
- ❍ No

SECTION 13: QUALITY OF LIFE

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

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

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

SECTION 14: COGNITIVE FUNCTION

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

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

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

SECTION 15: EMOTIONAL HEALTH

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

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

SECTION 16: FINANCIAL CONCERNS

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

16.1 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

16.2 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

16.3 Has your income changed since your cancer diagnosis?

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

16.4 Do you own any of the following assets? By own we mean that your name is on the title, even if loan payments are still being made. (Select all that apply.)

- ❍ The home you live in
- ❍ Car
- ❍ None of the above
- ❍ Other real estate besides where you live
- ❍ A business

16.5 Do you have any of the following? (Select all that apply)

- ❍ Retirement account (401(k), 403(b), IRA, etc.)
- ❍ Certificates of deposit (CDs)
- ❍ Savings account
- ❍ Stocks, bonds, or mutual funds
- ❍ Checking account
- ❍ None of the above

16.6 How many people live in your household (please include yourself)? _____

16.7 How long have you lived at your current address?

- ❍ Less than 6 months
- ❍ 6 months - 1 year
- ❍ More than 1 year, please specify how many years: _____

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

- ❍ Yes
- ❍ No

16.9 In order to pay bills related to your cancer treatment, have you had to do any of the following? (Select all that apply.)

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

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

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

16.11 Have you gone into debt or borrowed money to pay bills related to your cancer treatment?

❍ Yes → **Go To Question 16.12** ❍ No → **Go To Question 16.14**

16.12 What kind(s) of debt did you experience due to your cancer treatment? (Select all that apply.)

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

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

❍ Yes ❍ No

16.14 Have you **ever** turned down treatments for your cancer (chemotherapy, radiation, pain medications, anti-nausea medications, anti-diarrhea medications, or other recommended cancer treatments) because you were concerned about the costs?

❍ Yes ❍ No

16.16 Have you **ever** skipped doses of prescribed medication to save money?

❍ Yes ❍ No

16.17 Are you **currently** working (either full or part time) **OR** were you working **at the time of your cancer diagnosis**?

❍ Yes → **Go To Question 16.17** ❍ No → **Go To Section 17**

16.18 Since your cancer diagnosis, have you had to do any the following? (please answer yes or no for each option):

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

16.19 Since your cancer diagnosis, how much paid sick time have you used?

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

16.20 Since your cancer diagnosis, how much paid vacation time have you used?

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

16.21 Since your cancer diagnosis, how much unpaid time off work have you used?

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

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

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

SECTION 17: SOCIAL NEEDS

17.1 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

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

❍ Yes ❍ No

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

❍ Yes ❍ No

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

❍ Yes ❍ No

17.5 Generally, do you feel safe in your neighborhood?

❍ Yes ❍ No

SECTION 18: CAREGIVING RESPONSIBILITIES

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

❍ Yes → **Go To Question 18.2** ❍ No → **Go To Section 19**

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

I am his/her:

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

18.3 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 19: RELIGION

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

19.1 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
- ❍ Not applicable

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

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

SECTION 20: MEDICAL BELIEFS

20.1 For each item, please select the one response [per row] that best reflects your experience with your cancer doctor (oncologist).

	Never	Rarely	Some-times	Usually	Always
How often did the doctor speak too fast?	❍	❍	❍	❍	❍
How often did the doctor use words that were hard to understand?	❍	❍	❍	❍	❍
How often did the doctor find out what your concerns were?	❍	❍	❍	❍	❍
How often did the doctor let you say what you thought was important?	❍	❍	❍	❍	❍
How often did the doctor take your concerns about your health seriously?	❍	❍	❍	❍	❍
How often did the doctor explain your test results such as blood tests or CT scans?	❍	❍	❍	❍	❍
How often did the doctor clearly explain the result of your physical exam?	❍	❍	❍	❍	❍
How often did you and the doctor work out a treatment plan together?	❍	❍	❍	❍	❍
If there were treatment choices, how often did the doctor ask if you would like to help decide on the treatment?	❍	❍	❍	❍	❍
How often was the doctor concerned about your feelings?	❍	❍	❍	❍	❍
How often did the doctor really respect you as a person?	❍	❍	❍	❍	❍
How often did the doctor treat you as an equal?	❍	❍	❍	❍	❍

SECTION 21: DISCRIMINATION

The next few questions ask whether you have experienced discrimination during your life. Please answer yes or no to each question:

21.1 Do you feel you have ever personally experienced discrimination?

❍ Yes ⟶ **Go To Question 21.2** ❍ No ⟶ **Go To Last Page**

21.2 At any time in your life…	Yes	No	If yes, what was the main reason? (Select all that apply)									
			Ethnicity	Gender	Religion	Physical appearance	Sexual orientation	Income level or social class	Age	Race	Other	
Have you ever been unfairly fired or denied a promotion?	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	
For unfair reasons, have you ever not been hired for a job?	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	
Have you ever been unfairly stopped, searched, questioned, physically threatened or abused by the police?	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	
Have you ever been unfairly discouraged by a teacher or advisor from continuing your education?	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	
Have you ever unfairly received worse medical care than other people?	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	
Have you ever been unfairly prevented from moving into a neighborhood because the landlord or a realtor refused to sell or rent you a house or apartment?	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	
Have you ever moved into a neighborhood where your neighbors made life difficult for you or your family?	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	

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

Cancer Survivor Survey STUDY ID#:

Version: 4

Revised: 9/2/2021

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

Yearly Survey

We will contact you again in a year to complete a survey that will take about 30-45 minutes. This survey will ask about how you are doing and any changes in your health. 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 at your current mailing address. You will receive a $25 gift card for completing the follow up survey.

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____ ok to text ❍

Work Phone: (____) _____ - _____ Email: _____

Biospecimen Sample

An additional part of this study involves donating a small amount of blood (approximately 2.5 teaspoons). If you live in the tri-county (Wayne, Oakland, and Macomb) area and you agree below to donate blood, you will be contacted by our study phlebotomist, a research staff member who will draw your blood, to schedule an appointment. This can be done in your home at your convenience, or you can come to our office on Wayne State's campus in Midtown Detroit. The appointment will take about 15-30 minutes of your time. You will receive a second $25 gift card for donating blood.

Are you willing to set up an appointment to meet with the phlebotomist to donate blood?

❍ **Yes**

How can our phlebotomist best reach you?:

❍ Cell phone ❍ call ❍ text

❍ Home phone

❍ email

Best days / times to reach you:

❍ **No**

Would you be willing to donate saliva instead? *If yes, we will mail you a kit that you can use to collect the saliva and send it back to us. There is no cost for postage, and you will receive a second $25 gift card for donating saliva. Are you willing to donate saliva?*

❍ Yes ❍ No

Other Research Studies

Would you like to be contacted in the future about other research opportunities?

(By selecting yes it means that you *may* be invited to participate in other research studies but it does not mean that you must participate.)

❍ 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

Caregiver

Caregivers are unpaid loved ones who give the person with cancer physical and emotional care. They may be spouses, partners, family members, or close friends. Most often, they are not trained for the caregiver job. Many times, they may be the lifeline of the person with cancer.

Do you have a main unpaid caregiver who might be interested in taking a survey related to their experience as a caregiver of a cancer survivor? They will receive a $25 gift card for their time. If you are interested, we will have you complete a very brief form to identify the caregiver, which you can return to us once they have expressed interest in learning more about the survey. If you identify someone, and they later choose not to participate, that is OK.

❍ Yes ❍ No

WAYNE STATE
School of Medicine