



Life and Longevity after Cancer

Instructions:

This booklet has two sections.

- The first section is about the cancer, cancer treatments, and health issues after cancer treatment. The questions about treatment are about the treatments that you received right after the cancer diagnosis. The section also includes questions about health insurance.
- The second section is about your experience since the diagnosis of cancer.

CORRECT MARK

- **Use a pencil.**
- **Darken the circle completely next to the answer you choose.**
- **Erase cleanly any marks you wish to change.**
- **Do not make any stray marks on this form.**



INCORRECT MARKS



Date Received: --
Month Day Year

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Reviewed By: | | | | |

Language: ☒ ¹ E ☐ ² S

○ RCR



SERIAL #

PLEASE MAKE NO MARKS IN THIS AREA

Please complete the following questions regarding treatments you may have had for cancer. If you have had more than one type of cancer, please refer only to the cancer noted in the cover letter.

1. After you were first diagnosed with cancer, did you have **chemotherapy**? This means you took a drug by pill or through an IV to kill cancer cells. Some drugs might have made you sick to your stomach, lose your hair, or itch, for example.

☒ ¹ Yes

☐ ⁰ No

☐ ⁹ Don't know

Go to question 2 below.

Name of doctor and facility where you received chemotherapy.

1.1 Doctor's name: _____

1.2 Name of facility: _____

1.3 City and State of facility: _____

1.4 Date chemotherapy started: _____ - _____ - _____
month year

1.5 Date chemotherapy ended: _____ - _____ - _____
month year

2. Did you have **radiation** to treat your cancer? There are two types of radiation treatment to consider: Beam radiation (external radiation) is given by a machine in a hospital or clinic and directed to a specific part of your body; or an implant (internal radiation) is placed in your body, usually under anesthesia, and delivers radiation continuously.

☒ ¹ Yes

☐ ⁰ No

☐ ⁹ Don't know

Go to the next page.

Name of doctor and facility where you received radiation therapy.

2.1 Doctor's name: _____

2.2 Name of facility: _____

2.3 City and State of facility: _____

2.4 Date radiation started: _____ - _____ - _____
month year

2.5 Date radiation ended: _____ - _____ - _____
month year

Go to the next page. →

☒ ¹ Yes

☐ No

○⁹ Don't know

Go to the next page.

3.1 Doctor's name: _____

3.2 Name of facility: _____

3.3 City and State of facility:

3.4 Did a different doctor prescribe the most recent hormonal therapy?

☒ ¹ Yes

☐ No

→ Go to the next page.

3.5 Doctor's name:

3.6 Name of facility: _____

3.7 City and State of facility: _____

3.8 Date first hormonal therapy started: _____ - _____
month year

3.9 Date first hormonal therapy ended: _____ - _____
month year

Go to the next page. —▶

[illegible]

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4. Did you have any other type of treatment for your cancer such as **Herceptin** (a pill), a **tumor vaccine** (a shot), or a **stem cell** or **bone marrow transplant** (clinic procedure)?

☐ Yes

☐ No

☐ Don't know

Go to the next page.

Treatment

Doctor and Facility

4.1 Herceptin ☐ Yes →
☐ No

Doctor's name: _____

Name of facility: _____

City and State of facility: _____

Date treatment started: _____ - _____
month year4.2 Tumor Vaccine ☐ Yes →
☐ No

Doctor's name: _____

Name of facility: _____

City and State of facility: _____

Date treatment started: _____ - _____
month year4.3 Transplant ☐ Yes →
☐ No

Doctor's name: _____

Name of facility: _____

City and State of facility: _____

Date treatment started: _____ - _____
month year4.4 Other ☐ Yes →
☐ No

Doctor's name: _____

Name of facility: _____

Specify: _____

City and State of facility: _____

Date treatment started: _____ - _____
month year

Go to the next page. →

5. We are interested in learning about any health issues that you experienced after the completion of your initial cancer treatments.

Please indicate the symptoms that were **NEW** to you after your cancer treatment, and not due to some other known medical condition.

Did this occur?			If yes, how soon after treatment did symptoms occur -- in a matter of days, months, or years?			Do you still have the symptom?		Have you been treated for the symptom?	
	No	Yes	Days	Months	Years	No	Yes	No	Yes
5.1 Low blood counts (anemia, neutropenia)	☐ 0	☐ 1 →	☐ 1	☐ 2	☐ 3	☐ 0	☐ 1	☐ 0	☐ 1
5.2 High blood pressure	☐ 0	☐ 1 →	☐ 1	☐ 2	☐ 3	☐ 0	☐ 1	☐ 0	☐ 1
5.3 Kidney problems	☐ 0	☐ 1 →	☐ 1	☐ 2	☐ 3	☐ 0	☐ 1	☐ 0	☐ 1
5.4 Liver problems	☐ 0	☐ 1 →	☐ 1	☐ 2	☐ 3	☐ 0	☐ 1	☐ 0	☐ 1
5.5 Blood clots (venous thromboembolisms)	☐ 0	☐ 1 →	☐ 1	☐ 2	☐ 3	☐ 0	☐ 1	☐ 0	☐ 1
5.6 Nerve problems tingling sensations	☐ 0	☐ 1 →	☐ 1	☐ 2	☐ 3	☐ 0	☐ 1	☐ 0	☐ 1
5.7 Hearing changes	☐ 0	☐ 1 →	☐ 1	☐ 2	☐ 3	☐ 0	☐ 1	☐ 0	☐ 1
5.8 Skin rash or other skin disorders	☐ 0	☐ 1 →	☐ 1	☐ 2	☐ 3	☐ 0	☐ 1	☐ 0	☐ 1
5.9 Memory problems	☐ 0	☐ 1 →	☐ 1	☐ 2	☐ 3	☐ 0	☐ 1	☐ 0	☐ 1
5.10 Aching joints	☐ 0	☐ 1 →	☐ 1	☐ 2	☐ 3	☐ 0	☐ 1	☐ 0	☐ 1
5.11 Hot flashes	☐ 0	☐ 1 →	☐ 1	☐ 2	☐ 3	☐ 0	☐ 1	☐ 0	☐ 1
5.12 Radiation burns	☐ 0	☐ 1 →	☐ 1	☐ 2	☐ 3	☐ 0	☐ 1	☐ 0	☐ 1
5.13 Shortness of breath	☐ 0	☐ 1 →	☐ 1	☐ 2	☐ 3	☐ 0	☐ 1	☐ 0	☐ 1
5.14 Mouth sores or dry mouth	☐ 0	☐ 1 →	☐ 1	☐ 2	☐ 3	☐ 0	☐ 1	☐ 0	☐ 1
5.15 Insomnia or sleep problems	☐ 0	☐ 1 →	☐ 1	☐ 2	☐ 3	☐ 0	☐ 1	☐ 0	☐ 1
5.16 Heart disease, like congestive heart failure	☐ 0	☐ 1 →	☐ 1	☐ 2	☐ 3	☐ 0	☐ 1	☐ 0	☐ 1
5.17 Bleeding too easily	☐ 0	☐ 1 →	☐ 1	☐ 2	☐ 3	☐ 0	☐ 1	☐ 0	☐ 1
5.18 Weight gain > 10 lbs.	☐ 0	☐ 1 →	☐ 1	☐ 2	☐ 3	☐ 0	☐ 1	☐ 0	☐ 1
5.19 Other: Specify:	☐ 0	☐ 1 →	☐ 1	☐ 2	☐ 3	☐ 0	☐ 1	☐ 0	☐ 1

Go to the next page. →

6. Has your doctor ever told you that this cancer came back (a recurrence), that it had spread, or that you now have another cancer of this same type?

☒ ¹ Yes

☐ No

○⁹ Don't know

Go to question 7 below.

Name of the doctor who told you that the cancer came back.

6.1 Doctor's name: _____

6.2 City and State:

6.3 Date: -
 month year

7. Please tell us the type of health insurance that you had when you were first diagnosed with cancer and the type that you currently have. For each type of insurance coverage, please mark one circle under “Insurance coverage at diagnosis” and one circle under “Current insurance coverage.”

Go to the next page. —→

PLEASE MAKE NO MARKS IN THIS AREA

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These next questions refer to the present time.

8. Do you often feel sad or depressed? (Please mark the best answer).

☒¹ Yes ☐⁰ No

9. Please rate your pain by marking one circle that best describes your pain at its worst **in the last 24 hours**.

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
 No pain Pain as bad as you can imagine

10. Please mark one circle below to best reflect your feelings **during the past week**, including today.

10.1 Your overall level of anxiety?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
 None Moderate Worst

10.2 Your overall level of fatigue?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
 None Moderate Worst

10.3 Your overall level of distress?

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10
 None Moderate Worst

11. People sometimes look to others for companionship, assistance, or other types of support. This question covers the types of support that would be available to you if you needed it. Please mark one circle based on the support available to you during the **past 4 weeks**.

How often is someone available...	None of the time	A little of the time	Some of the time	Most of the time	All of the time
11.1 To take you to the doctor if you need to go?	☐ ¹	☐ ²	☐ ³	☐ ⁴	☐ ⁵
11.2 To have a good time with?	☐ ¹	☐ ²	☐ ³	☐ ⁴	☐ ⁵
11.3 To hug you?	☐ ¹	☐ ²	☐ ³	☐ ⁴	☐ ⁵
11.4 To prepare your meals if you are unable to for yourself?	☐ ¹	☐ ²	☐ ³	☐ ⁴	☐ ⁵
11.5 To understand your problems?	☐ ¹	☐ ²	☐ ³	☐ ⁴	☐ ⁵

Go to the next page. →

12. In the next section is a set of statements about how you might feel. Please indicate which of the following four possible answers best captures how often you feel the way that is described in each statement.

	Often	Some of the time	Hardly ever (or never)	No answer
12.1 How often do you feel you lack companionship?	☐ ¹	☐ ²	☐ ³	☐ ⁴
12.2 How often do you feel left out?	☐ ¹	☐ ²	☐ ³	☐ ⁴
12.3 How often do you feel isolated from others?	☐ ¹	☐ ²	☐ ³	☐ ⁴

13. What is your current weight? lbs.

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14. What is your current marital status?

☐ ¹ Married/living as married

☐ ³ Divorced/separated

☐ ² Widowed

☐ ⁴ Never married

Thank you.

Please take a moment to review any questions you may have missed.

Comments



PLEASE MAKE NO MARKS IN THIS AREA

SERIAL #



The LILAC Study

Life and Longevity after Cancer

Thank you for completing the survey we sent last year. This year we are asking questions about how you are doing since your cancer treatment. Please answer each question as best you can. Thank you for your help as we try to better understand cancer survivors' quality of life.

MARKING INSTRUCTIONS

- You may use a pencil or a pen (blue or black only).
- Darken the circle completely next to the answer you choose.
- To change an answer:
 - If you are using a pencil, cleanly erase the incorrect mark.
 - If you are using a pen, mark an X through the incorrect mark.
- Please do not make any stray marks on this form.

CORRECT MARK



INCORRECT MARKS



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Date Received:	- (MM/DD/YY)	- Affix label here -
Reviewed By:		Participant ID: -
		First Name M.I.
		Last Name
Contact Type:	☐ 1 Phone ☐ 2 Mail ☐ 3 CDS	☐ FCA ☐ OUI ☐ OU2

1. In the past year, has your doctor ever told you that your cancer came back (a recurrence), that it had spread, or that you now have another cancer of this same type?

☐ 1 Yes

☐ 0 No

☐ 9 Don't know

Go to question 2 on the next page.

- 1.1 Did you receive any of the following treatment for this cancer? (Mark all that apply.)

☐ 1 Surgery

☐ 5 No treatment

☐ 2 Chemotherapy

☐ 9 Don't know

☐ 3 Radiation therapy

☐ 4 Hormone-related (pills such as Arimidex, Ferara, Megace, Tamoxifen)



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PLEASE MAKE NO MARKS IN THIS AREA

2. Please estimate your weight to the nearest pound for each of the following times in your life.

Weight in pounds

2.1 What is your current weight? pounds

2.2 What was your weight when you were first diagnosed with cancer? pounds

2.3 What was your weight two years after diagnosis? pounds

2.4 If you lost weight during the first two years after your cancer diagnosis, was the weight loss intentional? ☐¹ Yes ☐⁰ No
☐² Didn't lose weight

3. Are you currently taking any of the following medications at least 3 times per week?

3.1 Aspirin (Anacin, Bayer, Bufferin, Excedrin, baby aspirin, etc.) ☐¹ Yes ☐⁰ No

3.2 Acetaminophen (Tylenol, etc.) ☐¹ Yes ☐⁰ No

3.3 Ibuprofen (Advil, Motrin, Nuprin, etc.) ☐¹ Yes ☐⁰ No

3.4 Other anti-inflammatory pain medicines (Aleve, Anaprox, Naprosyn, Ketoprofen, Relafen, etc.) ☐¹ Yes ☐⁰ No

3.5 Multivitamin ☐¹ Yes ☐⁰ No

4. Have you ever taken:

Yes

No

Date Started
(MM/YY)

Date Stopped
(if no longer taking)
(MM/YY)

4.1 Celebrex (celecoxib) ☐¹ ☐⁰

4.2 Statin cholesterol-lowering drug (Crestor, Lescol, Lipitor, Lovastatin, Mevacor, Pravachol, Zocor) ☐¹ ☐⁰

4.3 Bextra (valdecoxib) ☐¹ ☐⁰

4.4 Metformin ☐¹ ☐⁰

4.5 ACE inhibitors (Altace, enalapril, lisinopril, ramipril, Zestril) ☐¹ ☐⁰

4.6 Antidepressants (Amitriptylene, Celexa, Citalopram, Elavil, Fluoxetine, Prozac, Paroxetine, Paxil, Sertraline, Zoloft) ☐¹ ☐⁰

4.7 Bisphosphonates (Actonel, alendronate, Atelvia, Boniva, Fosamax, ibandronate, Reclast, risedronate, zoledronic acid) ☐¹ ☐⁰

Go to the next page. →

7. These questions are about people you see and groups you are in.**7.1 In the past month**, how often have you gone to a religious service or to a church?☐ ¹Not at all in
the past
month☐ ²Once in the
past month☐ ³2 or 3 times
in the past
month☐ ⁴

Once a week

☐ ⁵2 to 6 times
a week☐ ⁶

Every day

7.2 In the past month, how often have you gone to meetings of clubs, lodges or other groups?☐ ¹Not at all in
the past
month☐ ²Once in the
past month☐ ³2 or 3 times
in the past
month☐ ⁴

Once a week

☐ ⁵2 to 6 times
a week☐ ⁶

Every day

7.3 How many living children do you have?☐ ⁰

None

☐ ¹

1-2

☐ ²

3-5

☐ ³

6 or more

7.4 How many of your children do you see at least once a month?☐ ⁰

None

☐ ¹

1-2

☐ ²

3-5

☐ ³

6 or more

7.5 Apart from your children, how many relatives do you have with whom you feel close?☐ ⁰

None

☐ ¹

1-2

☐ ²

3-5

☐ ³

6-9

☐ ⁴

10 or more

7.6 Apart from your children, how many close relatives do you see at least once a month?☐ ⁰

None

☐ ¹

1-2

☐ ²

3-5

☐ ³

6-9

☐ ⁴

10 or more

7.7 How many close friends do you have?☐ ⁰

None

☐ ¹

1-2

☐ ²

3-5

☐ ³

6-9

☐ ⁴

10 or more

7.8 How many of these close friends do you see at least once a month?☐ ⁰

None

☐ ¹

1-2

☐ ²

3-5

☐ ³

6-9

☐ ⁴

10 or more

7.9 How much of the time do you have someone with whom you can have a good time or who helps you get your mind off things?☐ ¹None of
the time☐ ²A little of
the time☐ ³Some of
the time☐ ⁴Most of
the time☐ ⁵

All of the time

Go to the next page. →

In the past 7 days:

Never About once a week 2 to 3 times a week Nearly every day Several times a day

- | | | | | | | |
|-------|--|------------------------------------|------------------------------------|------------------------------------|------------------------------------|------------------------------------|
| 10.6 | I have had trouble remembering new information, like phone numbers or simple instructions. | ☐ ₀ | ☐ ₁ | ☐ ₂ | ☐ ₃ | ☐ ₄ |
| 10.7 | I have had trouble recalling the name of an object while talking to someone. | ☐ ₀ | ☐ ₁ | ☐ ₂ | ☐ ₃ | ☐ ₄ |
| 10.8 | I have had trouble finding the right word(s) to express myself. | ☐ ₀ | ☐ ₁ | ☐ ₂ | ☐ ₃ | ☐ ₄ |
| 10.9 | I have used the wrong word when I referred to an object. | ☐ ₀ | ☐ ₁ | ☐ ₂ | ☐ ₃ | ☐ ₄ |
| 10.10 | I have had trouble saying what I mean in conversations with others. | ☐ ₀ | ☐ ₁ | ☐ ₂ | ☐ ₃ | ☐ ₄ |
| 10.11 | I have walked into a room and forgotten what I meant to get or do there. | ☐ ₀ | ☐ ₁ | ☐ ₂ | ☐ ₃ | ☐ ₄ |
| 10.12 | I have had to work really hard to pay attention or I would make a mistake. | ☐ ₀ | ☐ ₁ | ☐ ₂ | ☐ ₃ | ☐ ₄ |
| 10.13 | I have forgotten names of people soon after being introduced. | ☐ ₀ | ☐ ₁ | ☐ ₂ | ☐ ₃ | ☐ ₄ |
| 10.14 | My reactions in everyday situations have been slow. | ☐ ₀ | ☐ ₁ | ☐ ₂ | ☐ ₃ | ☐ ₄ |
| 10.15 | I have had to work harder than usual to keep track of what I was doing. | ☐ ₀ | ☐ ₁ | ☐ ₂ | ☐ ₃ | ☐ ₄ |
| 10.16 | My thinking has been slower than usual. | ☐ ₀ | ☐ ₁ | ☐ ₂ | ☐ ₃ | ☐ ₄ |
| 10.17 | I have had to work harder than usual to express myself clearly. | ☐ ₀ | ☐ ₁ | ☐ ₂ | ☐ ₃ | ☐ ₄ |
| 10.18 | I have had to use written lists more often than usual so I would not forget things. | ☐ ₀ | ☐ ₁ | ☐ ₂ | ☐ ₃ | ☐ ₄ |
| 10.19 | I have trouble keeping track of what I am doing if I am interrupted. | ☐ ₀ | ☐ ₁ | ☐ ₂ | ☐ ₃ | ☐ ₄ |
| 10.20 | I have trouble shifting back and forth between different activities that require thinking. | ☐ ₀ | ☐ ₁ | ☐ ₂ | ☐ ₃ | ☐ ₄ |

Go to the next page. →

11. Think about the walking you do outside the home. How often do you walk outside the home for more than 10 minutes without stopping? (Mark only one.)

☐ ⁰ Rarely or never → Go to Question 12.

☐ ¹ 1 to 3 times each month

☐ ² 1 time each week

☐ ³ 2 to 3 times each week

☐ ⁴ 4 to 6 times each week

☐ ⁵ 7 or more times each week

When you walk outside the home for more than 10 minutes without stopping,

11.1 How many minutes do you usually walk?

☐ ¹ Less than 20 minutes

☐ ² 20 to 39 minutes

☐ ³ 40 to 59 minutes

☐ ⁴ 1 hour or more

11.2 What is your usual speed?

☐ ¹ Casual strolling (2 miles per hour)

☐ ² Average or normal (2-3 miles an hour)

☐ ³ Fairly fast (3-4 miles an hour)

☐ ⁴ Very fast (more than 4 miles an hour)

☐ ⁹ Don't know

12. Not counting walking outside the home, how often each week (7 days) do you usually do the exercises below?

12.1 **Moderate or strenuous exercise.** For example, biking outdoors, using an exercise machine (like a stationary bike or treadmill), aerobics, swimming, folk or popular dancing, jogging, tennis.

☐ ⁰ Never → Go to Question 12.3 on the next page.

☐ ¹ 1 day per week

☐ ² 2 days per week

☐ ³ 3 days per week

☐ ⁴ 4 days per week

☐ ⁵ 5 or more days per week

12.2 How long do you usually exercise like this at one time?

☐ ¹ Less than 20 minutes

☐ ² 20 to 39 minutes

☐ ³ 40 to 59 minutes

☐ ⁴ 1 hour or more

Go to the next page. →

○₀ Never → Go to Question 13.

- ☐ 1 1 day per week
- ☐ 2 2 days per week
- ☐ 3 3 days per week
- ☐ 4 4 days per week
- ☐ 5 5 or more days per week

- ☐ 1 Less than 20 minutes
- ☐ 2 20 to 39 minutes
- ☐ 3 40 to 59 minutes
- ☐ 4 1 hour or more

Not at all	A little	Quite a bit	Very much

- | | | | | | |
|-------------|--|-------------------------|-------------------------|-------------------------|-------------------------|
| 13.1 | In general, how satisfied are you with your appearance? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 13.2 | Have you felt less physically attractive as a result of your cancer or treatment? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 13.3 | Have you been dissatisfied with the appearance of any scar(s) that resulted from your cancer treatments? | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |

Symptom did not occur	Symptom occurred and was:		
	Mild	Moderate	Severe

- | | | | | | |
|--------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|
| 14.1 | Abdominal/pelvic pain | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 14.2 | Bloating or gas | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 14.3 | Constipation | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 14.4 | Coughing or wheezing | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 14.5 | Diarrhea | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 14.6 | Difficulty breathing | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 14.7 | Difficulty sleeping | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 14.8 | Feeling anxious | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 14.9 | Feeling depressed | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 14.10 | Feeling tired | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 14.11 | General aches and pains | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |
| 14.12 | Headaches or migraines | ☐ 0 | ☐ 1 | ☐ 2 | ☐ 3 |

Go to the next page. —→

PLEASE MAKE NO MARKS IN THIS AREA

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	In the <u>past 4 weeks</u> , did you have:	Symptom did not occur	Symptom occurred and was:		
			Mild	Moderate	Severe
14.13	Heartburn	☐ ₀	☐ ₁	☐ ₂	☐ ₃
14.14	Hot flashes	☐ ₀	☐ ₁	☐ ₂	☐ ₃
14.15	Joint pain or stiffness	☐ ₀	☐ ₁	☐ ₂	☐ ₃
14.16	Night sweats	☐ ₀	☐ ₁	☐ ₂	☐ ₃
14.17	Pain or burning while urinating	☐ ₀	☐ ₁	☐ ₂	☐ ₃
14.18	Shortness of breath	☐ ₀	☐ ₁	☐ ₂	☐ ₃
14.19	Trouble concentrating	☐ ₀	☐ ₁	☐ ₂	☐ ₃
14.20	Uncontrolled leaking of feces	☐ ₀	☐ ₁	☐ ₂	☐ ₃
14.21	Uncontrolled leaking of urine	☐ ₀	☐ ₁	☐ ₂	☐ ₃
14.22	Vaginal or genital discharge	☐ ₀	☐ ₁	☐ ₂	☐ ₃
14.23	Vaginal or genital dryness	☐ ₀	☐ ₁	☐ ₂	☐ ₃
14.24	Vaginal or genital irritation or itching	☐ ₀	☐ ₁	☐ ₂	☐ ₃

15. Now for some questions about your diet.

15.1 How many cups of fruit and vegetables do you eat in **an average day**?

Example:

One cup of fruit = 1 banana, 1 apple, 15 grapes

One cup of vegetables = 1 ear of corn, 1 potato, 2 cups cooked greens,
1 cup uncooked greens, 2 celery stalks, or 12 baby carrots

☐₁ Less than 4 ½ cups ☐₂ 4 ½ cups or more ☐₉ Don't know

15.2 Do you drink **less** than 36 ounces (4 ½ cups) of beverages with added sugar **weekly**?
(For example: regular soft drinks, fruitades, punch, sweet tea.)

☐₁ Yes ☐₀ No ☐₉ Don't know

15.3 Do you eat 1500 milligrams or **less** of sodium (salt) **daily**? If you don't track your daily sodium intake by reading the food labels, you may answer 'yes' if you do at least two of the following:

- 1) Avoid eating pre-packaged processed food or eat low-sodium versions
- 2) Avoid eating out or ask for low-sodium preparations, or
- 3) Cook at home without adding salt

☐₁ Yes ☐₀ No ☐₉ Don't know

Go to the next page. →

- ☒₁ Yes ☐₀ No ☐₉ Don't know

- ☒¹ Yes ☐⁰ No ☐⁹ Don't know

☐₁ Yes ☐₀ No → **Go to Question 18 on the next page.**

- ☐₁ Yes ☐₀ No → **Go to Question 18 on the next page.**

- ¹ Hand
- ² Upper arm (above the elbow)
- ³ Lower arm (below the elbow)

- ☐ 1 Clothes
- ☐ 2 Your appearance
- ☐ 3 Exercise
- ☐ 4 Ability to do routine activities such as household chores
- ☐ 5 Swelling does not interfere
- ☐ 6 Other (Specify): _____

- ☐₁ Yes ☐₀ No

Go to the next page. —→

PLEASE MAKE NO MARKS IN THIS AREA

SERIAL #

18. Were you diagnosed with **endometrial, ovarian or colorectal cancer**?

☐₁ Yes

☐₀ No

→ Go to Question 20 on the next page.



19. The following statements are about swelling or discomfort in the lower part of your body. Please answer for the side of your lower body that is **affected the most**.

On average, in the past 4 weeks:

Not
at all

A little
bit

Somewhat

Quite a
bit

Very
much

19.1 The skin on my leg has felt tight.

☐₀

☐₁

☐₂

☐₃

☐₄

19.2 The skin above my ankle has felt tight.

☐₀

☐₁

☐₂

☐₃

☐₄

19.3 My leg felt heavy.

☐₀

☐₁

☐₂

☐₃

☐₄

19.4 I have had pain or discomfort in my leg.

☐₀

☐₁

☐₂

☐₃

☐₄

19.5 My leg has been noticeably smaller when I get out of bed in the morning.

☐₀

☐₁

☐₂

☐₃

☐₄

19.6 I have had swelling in my foot.

☐₀

☐₁

☐₂

☐₃

☐₄

19.7 I have had swelling around my ankle.

☐₀

☐₁

☐₂

☐₃

☐₄

19.8 I have had swelling in my lower leg (including my knee).

☐₀

☐₁

☐₂

☐₃

☐₄

19.9 I have had swelling in my upper leg.

☐₀

☐₁

☐₂

☐₃

☐₄

19.10 I have had swelling in my buttocks.

☐₀

☐₁

☐₂

☐₃

☐₄

19.11 I have had swelling in my hip (on the side below the waist).

☐₀

☐₁

☐₂

☐₃

☐₄

19.12 I have had swelling below my stomach (below my belly button).

☐₀

☐₁

☐₂

☐₃

☐₄

19.13 I have had swelling in my genital area.

☐₀

☐₁

☐₂

☐₃

☐₄

19.14 Does this swelling interfere with your daily activities?

☐₁ Yes

☐₀ No

☐₂ No swelling

19.15 What does it interfere with? (Mark all that apply.)

☐₁ Employment

☐₄ Housework or gardening

☐₂ Recreation

☐₅ Social activities

☐₃ Rest or sleep

☐₈ Other (Specify): _____

Go to the next page. →



The LILAC Study

Life and Longevity after Cancer

Thank you for completing the survey we sent last year. This year we are asking questions about how you are doing since your cancer treatment. Please answer each question as best you can. Thank you for your help as we try to better understand cancer survivors' quality of life.

OFFICE USE ONLY	
Date Received: - -	 {memId} {fullName}
Reviewed By: - -	
Contact Type: ☐ ¹ Phone ☐ ² Mail ☐ FCR ☐ OUI	

1. In the past year, has your doctor ever told you that your cancer came back (a recurrence), that it had spread, or that you now have another cancer of this same type?

☐ ¹ Yes ☐ ⁰ No ☐ ⁹ Don't know → Go to question 2.

1.1 Did you receive any of the following treatment for this cancer? (Mark all that apply.)

- ☐ ¹ Surgery ☐ ⁵ No treatment
☐ ² Chemotherapy ☐ ⁹ Don't know
☐ ³ Radiation therapy
☐ ⁴ Hormone-related (pills such as Tamoxifen, Arimidex, Femara, Megace)

These next questions refer to the present time.

2. Do you often feel sad or depressed? (Mark the best answer.)

☐ ¹ Yes ☐ ⁰ No

3. Please rate your pain by marking one circle that best describes your pain at its worst in the last 24 hours.

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	10
No Pain										Pain as bad as you can imagine

Continued on next page →

{SeqNum}

☐₁ Yes ☐₀ No ☐₉ Don't know