



200 First Street SW
Rochester, Minnesota 55905
507-284-2511

June 21, 2019

«FIRST» «LAST»
«ADDRESS_LINE1» «ADDRESS_LINE2»
«CITY», «STATE» «ZIPCODE»

Dear «FIRST» «LAST»:

Thank you for taking the time to discuss your health with us as part of our ongoing research study.

At your convenience, please complete the following document(s):

(documents included in letter are indicated below)

LEO 6 month Follow Up Questionnaire

When you complete the Questionnaire(s), please send them back in the enclosed postage paid envelope(s).

All information will be kept strictly confidential and will not become part of your medical record. If at any time you have any questions concerning this research study, please do not hesitate to contact us at 1-800-610-7093.

Thank you. Your participation is greatly appreciated.

Sincerely,

The Lymphoma Research Team



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Lymphoma Epidemiology of Outcomes (LEO) Follow-up Questionnaire (6 months)

****please answer based on what has occurred since the last follow-up (date)****

Date Form Completed	____/____/____ (mm/dd/yyyy)
What is your current weight?	_____ pounds
Have you received new treatment for lymphoma?	<input type="checkbox"/> No (skip to next question) <input type="checkbox"/> Yes (Please answer below) Clinic/Hospital Name where treatment was received: _____
Have you had a relapse or progression?	<input type="checkbox"/> No (skip to next question) <input type="checkbox"/> Yes (Please answer below) Clinic/Hospital Name where relapse/progression was detected: _____
Have you had any CT or PET scans to assess your lymphoma status?	<input type="checkbox"/> No (skip to next question) <input type="checkbox"/> Yes (Please answer below) Clinic/Hospital Name where scan was done: _____
Have you been diagnosed with another type of cancer?	<input type="checkbox"/> No (skip to next question) <input type="checkbox"/> Yes (Please answer below) Clinic/Hospital Name where new cancer was diagnosed: _____
Heart Disease	<input type="checkbox"/> No (skip to next question) <input type="checkbox"/> Yes (select all that apply) <ul style="list-style-type: none"> <input type="checkbox"/> Coronary Heart Disease or Heart Attack (include stents) <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Pericardial Disease or Cardiomyopathy <input type="checkbox"/> Heart Valve Disease <input type="checkbox"/> Heart Rhythm Problems (Arrhythmias or Atrial Fibrillation) <input type="checkbox"/> Other Heart Disease
Stroke	<input type="checkbox"/> No <input type="checkbox"/> Yes
Sugar Diabetes	<input type="checkbox"/> No (skip to next question) <input type="checkbox"/> Yes (select type below) <ul style="list-style-type: none"> <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Type Unknown
Respiratory (breathing) disease	<input type="checkbox"/> No (skip to next question) <input type="checkbox"/> Yes (select all that apply) <ul style="list-style-type: none"> <input type="checkbox"/> Asthma <input type="checkbox"/> Emphysema <input type="checkbox"/> Chronic bronchitis

«LEO_ID»

«LOCAL_ID»

TIMEPOINT: «timepoint»

Lymphoma Epidemiology of Outcomes (LEO) Follow-up Questionnaire (6 months)

****please answer based on what has occurred since the last follow-up (date)****

	<input type="checkbox"/> Chronic obstructive pulmonary disease
Hepatitis	<input type="checkbox"/> No (skip to next question) <input type="checkbox"/> Yes (select all that apply) <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Don't know
Other Liver problems	<input type="checkbox"/> No (skip to next question) <input type="checkbox"/> Yes (select all that apply) <input type="checkbox"/> Cirrhosis <input type="checkbox"/> Non-alcoholic liver disease
Digestive problems	<input type="checkbox"/> No (skip to next question) <input type="checkbox"/> Yes (select all that apply) <input type="checkbox"/> Ulcer <input type="checkbox"/> Colitis
Sinusitis	<input type="checkbox"/> No <input type="checkbox"/> Yes
Shingles	<input type="checkbox"/> No <input type="checkbox"/> Yes
Progressive Multifocal Leukoencephalopathy ("PML")	<input type="checkbox"/> No <input type="checkbox"/> Yes
Osteoporosis (Brittle Bones)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Hip Fracture (broken hip)	<input type="checkbox"/> No <input type="checkbox"/> Yes
Other Broken Bones	<input type="checkbox"/> No <input type="checkbox"/> Yes
Premature Menopause	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Not applicable
Infertility	<input type="checkbox"/> No <input type="checkbox"/> Yes
Taken medication or seen a health care provider for depression?	
<input type="checkbox"/> No <input type="checkbox"/> Yes	
Taken medication or seen a health care provider for anxiety?	
<input type="checkbox"/> No <input type="checkbox"/> Yes	
Taken medication or seen a health care provider for memory problems?	
<input type="checkbox"/> No <input type="checkbox"/> Yes	
Blood Clot	<input type="checkbox"/> No (skip to next question) <input type="checkbox"/> Yes (Please select all that apply) <input type="checkbox"/> Deep Vein Thrombosis (DVT) Clot in (arms?), legs or abdomen <input type="checkbox"/> Pulmonary Embolism (PE) Clot in lungs

Lymphoma Epidemiology of Outcomes (LEO) Follow-up Questionnaire (6 months)

****please answer based on what has occurred since the last follow-up (date)****

<p>Are you currently on Blood Thinning Medication? (other than aspirin or Plavix)</p>	<p><input type="checkbox"/> No (skip to next question)</p> <p><input type="checkbox"/> Yes (Please provide type below)</p> <p><input type="checkbox"/> Coumadin (Warfarin)</p> <p><input type="checkbox"/> enoxaparin (Lovenox)</p> <p><input type="checkbox"/> dabigatran (Pradaxa)</p> <p><input type="checkbox"/> apixaban (Eliquis)</p> <p><input type="checkbox"/> rivaroxaban (Xarelto)</p> <p><input type="checkbox"/> Heparin</p> <p><input type="checkbox"/> Other</p> <p><input type="checkbox"/> Don't know</p>
<p>How many times have you fallen in the last 6 months?</p>	<p>_____ (Number of times, if zero, enter 0)</p>
<p>Have you stayed overnight in the hospital in the last 6 months?</p>	<p><input type="checkbox"/> No</p> <p><input type="checkbox"/> Yes (Please answer below)</p> <p>REASON:</p> <p><input type="checkbox"/> Infection</p> <p><input type="checkbox"/> Cancer Treatment</p> <p><input type="checkbox"/> Other:</p>

*Scored Patient-Generated Subjective Global Assessment (PG-SCA) ©FD Ottery 2005, 2006, 2015 v3.22.15

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Thank you for taking the time to complete this form.

If at any time you have questions, please contact us at: 1-800-610-7093

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