

200 First Street SW

Rochester, Minnesota 55905

507-284-2511

February 13, 2019

«First Name» «Last Name»

«Current Address1» «Current Address2»

«Current City», «Current State» «Current Zipcode»

Dear «First Name» «Last Name»,

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)*

**«timepoint» Years Follow Up Questionnaire**

**Spore Registry Follow Up Questionnaire (Fact G)**

**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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| --- | --- | --- | --- | --- | --- |
| **Date Form Completed** | | \_\_\_\_/\_\_\_\_/\_\_\_\_\_\_\_\_ (mm/dd/yyyy) | | | |
| What is your current weight? | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_pounds | | | |
| Have you received new treatment for lymphoma? | | No (skip to next question)  Yes (Please answer below)  Clinic/Hospital Name where treatment was received: | | | |
| Have you had a relapse or progression? | | No (skip to next question)  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? | | No (skip to next question)  Yes (Please answer below)  Clinic/Hospital Name where scan was done:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Have you been diagnosed with another type of cancer? | | No (skip to next question)  Yes (Please answer below)  Clinic/Hospital Name where new cancer was diagnosed:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| Heart Disease | | No (skip to next question)  Yes (select all that apply)  Coronary Heart Disease or Heart Attack (include stents)  Congestive Heart Failure  Pericardial Disease or Cardiomyopathy  Heart Valve Disease  Heart Rhythm Problems (Arrhythmias or Atrial Fibrillation)  Other Heart Disease | | | |
| Stroke | | No  Yes | | | |
| Sugar Diabetes | | No (skip to next question)  Yes (select type below)  Type 1  Type 2  Type Unknown | | | |
| Respiratory (breathing) disease | | No (skip to next question)  Yes (select all that apply)  Asthma  Emphysema  Chronic bronchitis  Chronic obstructive pulmonary disease | | | |
| Hepatitis | | | No (skip to next question)  Yes (select all that apply)  Hepatitis A  Hepatitis B  Hepatitis C  Don’t know | | |
| Other Liver problems | | | No (skip to next question)  Yes (select all that apply)  Cirrhosis  Non-alcoholic liver disease | | |
| Digestive problems | | | No (skip to next question)  Yes (select all that apply)  Ulcer  Colitis | | |
| Sinusitis | | | No  Yes | |
| Shingles | | | No  Yes | |
| Progressive Multifocal Leukoencephalopathy (”PML”) | | | No  Yes | |
| Osteoporosis (Brittle Bones) | | | No  Yes | |
| Hip Fracture (broken hip) | | | No  Yes | |
| Other Broken Bones | | | No  Yes | |
| Premature Menopause | | | No  Yes  Not applicable | |
| Infertility | | | No  Yes | |
| Taken medication or seen a health care provider for depression? | | | | No  Yes |
| Taken medication or seen a health care provider for anxiety? | | | | No  Yes |
| Taken medication or seen a health care provider for memory problems? | | | | No  Yes |
| Blood Clot | No (skip to next question)  Yes (Please select all that apply)  Deep Vein Thrombosis (DVT) Clot in (arms?), legs or abdomen  Pulmonary Embolism (PE) Clot in lungs | | | |

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

\*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