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

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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

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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
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: _____.

These next questions ask about different ways lymphoma, its treatment, or the lasting effects of that treatment may have affected your work – that is, your hours, duties, or employment status. As you answer these questions, please think about the entire time from when you were first diagnosed with lymphoma to now.	
At any time from when you were first diagnosed with lymphoma until now, were you working for pay at a job or business?	☐ No ☐ Yes
IF YES to above question: At any time since your diagnosis, did you take extended paid time off from work, unpaid time off, or make a change in your hours, duties, or employment status?	☐ No ☐ Yes ☐ Not applicable
Because of your lymphoma, its treatment, or the lasting effects of that treatment, did any of your caregivers ever take extended paid time off work, unpaid time off, of make a change in their hours, duties or employment status?	☐ No ☐ Yes
Because of your lymphoma, its treatment, or the lasting effects of that treatment, did you or any of your caregivers take an extra job or work additional hours?	☐ No ☐ Yes
Have you or has anyone in your family had to borrow money or go into debt because of your lymphoma, its treatment, or the lasting effects of that treatment?	☐ No ☐ Yes

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

Did you or your family ever file for bankruptcy because of your lymphoma, its treatment, or the lasting effects of that treatment?	☐ No ☐ Yes
Please think about medical care visits for lymphoma, its treatment, or the lasting effects of that treatment. Have you ever been unable to cover your share of the cost of those visits?	☐ No ☐ Yes
At any time since you were first diagnosed with lymphoma, did you get all of the medical care, tests, or treatments that you or your doctor believed were necessary? ☐ No - if no, please answer reason to right (select all that apply) ☐ Yes, move to next question below	☐couldn't afford care ☐insurance company wouldn't approve or pay for care ☐had problems getting to the doctor's office ☐doctor did not accept your insurance ☐couldn't get time off work ☐didn't know where to go to get care ☐couldn't get child/adult care ☐didn't have time – care/test/treatment took too long ☐other reason
Have you or your family had to make any other kinds of financial sacrifices because of your lymphoma, its treatment, or the lasting effects of that treatment?	☐ No ☐ Yes
Have you ever worried about having to pay large medical bills related to your lymphoma?	☐ No ☐ Yes
We ask participants about their economic backgrounds because we think it is important to understand how people from different backgrounds differ in their experiences with lymphoma and treatment choices. Using the categories to the right, please indicate the annual income of your household. Include yourself and anyone with whom you live and share finances.	☐Less than $21,000 ☐$21,000 - $39,999 ☐$40,000 - 65,999 ☐$66,000 - $105,999 ☐$106,000 or more ☐I don't know ☐I choose not to answer

Please circle the number (0-10) best reflecting your response to the following that describes your feelings **during the past week, including today**.

Your Overall Quality of Life

0	1	2	3	4	5	6	7	8	9	10
As **BAD** as it can be										As **GOOD** as it can be

Below is a list of statements that other people with your illness have said are important.
By circling one (1) number per line, please indicate how true each statement has been for you during the past 7 days.

∴ **PHYSICAL WELL BEING**	**Not at all**	**A little bit**	**Some what**	**Quite a bit**	**Very Much**
I have a lack of energy	0	1	2	3	4
I have Nausea	0	1	2	3	4
Because of my physical condition, I have trouble meeting the needs of my family	0	1	2	3	4
I have pain	0	1	2	3	4
I am bothered by side effects of treatment	0	1	2	3	4
I feel ill	0	1	2	3	4

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I am forced to spend time in bed	0	1	2	3	4

∴ SOCIAL/FAMILY WELL BEING	Not at all	A little bit	Some what	Quite a bit	Very Much
I feel close to my friends	0	1	2	3	4
I get emotional support from my family	0	1	2	3	4
I get support from my friends	0	1	2	3	4
My family has accepted my illness	0	1	2	3	4
I am satisfied with family communication about my illness	0	1	2	3	4
I feel close to my partner (or the person who is my main support)	0	1	2	3	4
Regardless of your current level of sexual activity, please answer the following question. If you prefer not to answer it, please check this box ☐ and go to the next section					
I am satisfied with my sex life	0	1	2	3	4

By circling one (1) number per line, please indicate how true each statement has been for you **during the past 7 days.**

∴ EMOTIONAL WELL BEING	Not at all	A little bit	Some what	Quite a bit	Very Much
I feel sad	0	1	2	3	4
I am satisfied with how I am coping with my illness	0	1	2	3	4
I am losing hope in the fight against my illness	0	1	2	3	4
I feel nervous	0	1	2	3	4
I worry about dying	0	1	2	3	4
I worry that my condition will get worse	0	1	2	3	4

By circling one (1) number per line, please indicate how true each statement has been for you **during the past 7 days.**

∴ FUNCTIONAL WELL BEING	Not at all	A little bit	Some what	Quite a bit	Very Much
I am able to work (include work at home)	0	1	2	3	4
My work (include work at home) is fulfilling	0	1	2	3	4
I am able to enjoy life	0	1	2	3	4
I have accepted my illness	0	1	2	3	4
I am sleeping well	0	1	2	3	4
I am enjoying the things I usually do for fun	0	1	2	3	4
I am content with the quality of my life right now	0	1	2	3	4

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

By circling one (1) number per line, please indicate how true each statement has been for you **during the past 7 days.**

***ADDITIONAL CONCERNS	Not at all	A little bit	Some what	Quite a bit	Very Much
I have certain parts of my body where I experience pain	0	1	2	3	4
I am bothered by lumps or swelling in certain parts of my body (eg neck, armpits or groin)	0	1	2	3	4
I am bothered by fevers (especially of high body temperature	0	1	2	3	4
I have night sweats	0	1	2	3	4
I am bothered by itching	0	1	2	3	4
I have trouble sleeping at night	0	1	2	3	4
I get tired easily	0	1	2	3	4
I am losing weight	0	1	2	3	4
I have a loss of appetite	0	1	2	3	4
I have trouble concentrating	0	1	2	3	4
I worry about getting infections	0	1	2	3	4
I worry that I might get new symptoms of my illness	0	1	2	3	4
I feel isolated from others because of my illness or treatment	0	1	2	3	4
I have emotional ups and downs	0	1	2	3	4
Because of my illness, I have difficulty planning for the future	0	1	2	3	4

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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