****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?	☐ 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

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

	☐ 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

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

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

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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