Lymphoma Epidemiology of Outcomes (LEO) Follow-up Questionnaire (3 year)
****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

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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

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Question	Response
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___________
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: __________.

Have you used any of the following products for 12 months or longer?	
Cigar	☐ No (skip to next question) ☐ Yes If yes, how many years? ___ ___ years
Pipe	☐ No (skip to next question) ☐ Yes If yes, how many years? ___ ___ years
Snuff	☐ No (skip to next question) ☐ Yes If yes, how many years? ___ ___ years
Chewing tobacco	☐ No (skip to next question) ☐ Yes If yes, how many years? ___ ___ years

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

Question	Response
Have you smoked at least 100 cigarettes in your entire life?	☐ No (skip to next section) ☐ Yes (Please answer below) ☐ Don't know/Unsure (skip to next section)
If YES to the question above, how old were you when you first started smoking cigarettes on a regular basis?	___ ___ years old
On average, how many cigarettes did you or do you smoke per day?	☐ 1 to 10 per day ☐ 11 to 20 per day ☐ 21 to 30 per day ☐ 31 to 40 per day ☐ 41 or more per day
Do you currently smoke?	☐ No What age did you quit? __ __ years old ☐ Yes

Question	Response	
Did you ever live in the same household with someone who smoked cigarettes regularly?	☐ No (skip to next section) ☐ Yes (Please answer below) ☐ Don't know/Unsure (skip to next section)	
If YES to the question above, how many years altogether was this the case?	___ ___ years	
Please indicate the amount of secondhand exposure per day by the approximate combined number of cigarettes or packs smoked by the person(s) from your household.	☐ 1 to 10 cigarettes per day (up to ½ a pack) ☐ 11 to 20 cigarettes per day (½ to 1 pack) ☐ 21 to 40 cigarettes per day (1 to 2 packs) ☐ 41 to 60 cigarettes per day (2-3 packs) ☐ More than 60 cigarettes per day (3 packs or more)	
At what age(s) were you exposed to secondhand smoke from your household? (mark all that apply)	☐ Younger than 5 ☐ 5 to 9 years old ☐ 10 to 19 years old ☐ 20 to 29 years old ☐ 30 to 39 years old	☐ 40 to 49 years old ☐ 50 to 59 years old ☐ 60 to 69 years old ☐ 70 to 79 years old ☐ 80 and older

Question	Response
Did you ever work in an area where others smoked regularly in your presence?	☐ No (skip to next section) ☐ Yes (Please answer below) ☐ Don't know/Unsure (skip to next section)
If YES to the question above, how many years altogether was this the case?	___ ___ years
Please indicate the amount of secondhand exposure per day by the approximate combined number of cigarettes or packs smoked by the person(s) from your workplace.	☐ 1 to 10 cigarettes per day (up to ½ a pack) ☐ 11 to 20 cigarettes per day (½ to 1 pack) ☐ 21 to 40 cigarettes per day (1 to 2 packs) ☐ 41 to 60 cigarettes per day (2-3 packs) ☐ More than 60 cigarettes per day (3 packs or more)

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At what age(s) were you exposed to secondhand smoke from your household? (mark all that apply)	☐ Younger than 5 ☐ 5 to 9 years old ☐ 10 to 19 years old ☐ 20 to 29 years old ☐ 30 to 39 years old	☐ 40 to 49 years old ☐ 50 to 59 years old ☐ 60 to 69 years old ☐ 70 to 79 years old ☐ 80 and older

Over the past month, I would generally rate my activity as:	☐ Normal with no limitations ☐ Not my normal self, but able to be up and about with fairly normal activities ☐ Not feeling up to most things, but in bet or chair less than half the day ☐ Able to do little activity and spend most of the day in a bed or chair ☐ Pretty much bedridden, rarely out of bed
Which of the following best describes you?	☐ Working full time for pay (35 or more hours per week) ☐ Working part-time for pay ☐ Not working for pay at present (Please answer below) **Are you…** (Mark all that apply.) ☐ A full-time homemaker ☐ A seasonal worker ☐ In school ☐ Disabled ☐ Retired ☐ Other, Specify ___________________________
Are you currently…	☐ Married ☐ Living with someone in a marriage-like relationship ☐ Separated ☐ Divorced ☐ Widowed ☐ Never been married

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

	Never	Rarely (once)	Sometimes (2 or 3 times)	Often (about once a day)	Very often (several times a day)
My thinking has been slow	1	2	3	4	5
It has seemed like my brain was not working as well as usual	1	2	3	4	5
I have had to work harder than usual to keep track of what I was doing	1	2	3	4	5
I have had trouble shifting back and forth between different activities that require thinking	1	2	3	4	5

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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
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

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

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

Below is a list of statements that other people with your illness have said are important. Please circle or mark one number per line to indicate your response as it applies to the past 7 days.	
I worry about the financial problems I will have in the future as a result of my illness or treatment.	☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much
I am satisfied with my current financial situation.	☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much
I feel financially stressed	☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much
My cancer or treatment has reduced my satisfaction with my present financial situation.	☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

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

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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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