(Date)

First and Last Name
Address
Address

Dear (Send Salutation):

The EMPOWER research team would like to thank you for joining this important study. We really do value your effort to help us, which is needed to make this study a success. We believe this study has the potential to improve the quality of life and health care received by thousands of other cancer survivors just like you.

To make this study successful, it is very important that you complete the enclosed survey as well as sign and date the HIPAA authorization form. If you would like to complete the questionnaire online, please go to www.stjude.org/EMPOWER and enter your date of birth and the following password **XXXX**. Thanks again for being so generous of your time to stay involved in this study. We really do value and appreciate your participation in this important study.

If you have any questions or concerns, please call 1-800-775-2167.

Sincerely Yours,

Leslie L. Robison, Ph.D.
Principal Investigator, Long-Term Follow-Up Study
Director, Epidemiology and Cancer Control

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This form is your permission to use or disclose medical information that we would like you to sign. It will give us permission to obtain copies of portions of your medical record that we may need to review, such as treatment history for your cancer of similar illness, or pathology reports for a subsequent cancer.

LONG-TERM FOLLOW-UP STUDY
HIPAA[1] AUTHORIZATION TO USE AND DISCLOSE INDIVIDUAL HEALTH INFORMATION FOR RESEARCH

1. **Purpose.** As a research participant and at my request, I authorize Leslie L. Robison, Ph.D. and the researcher's staff to use and disclose my individual health information for the purpose of conducting the research project entitled Long-Term Follow-Up (LTFU) Study.

2. **Individual Health Information to be Used or Disclosed.** My individual health information that may be used or disclosed to conduct this research includes medical records since the diagnosis of a serious illness such as a cardiac condition or a cancer or similar illness.

3. **Parties Who May disclose My Individual Health Information.** The researcher and the researcher's staff may obtain my individual health information from hospitals, clinics, and health care providers who have treated me, and health plans that have paid for my care, during this study.

4. **Parties Who May Receive or Use My Individual Health Information.** The individual health information disclosed by parties listed in item 3 and information disclosed by me during the course of the research may be received and used by Leslie L. Robison, Ph.D., the researcher's staff, LTFU collaborators, the LTFU Biopathology Center (Columbus, OH), the LTFU Molecular Center (Cincinnati, OH), the LTFU Radiation Physics Center (Houston, TX), the LTFU Statistical Center (Seattle, WA), and the University of Colorado Cancer Center (Denver, CO)

5. **Right to Refuse to Sign this Authorization.** I do not have to sign this Authorization. If I decide not to sign the Authorization, I may not be allowed to participate in this study. However, my decision not to sign this authorization will not affect any other treatment, payment, or enrollment in health plans or eligibility for benefits.

6. **Right to Revoke.** I can change my mind and withdraw this authorization at any time by sending a written notice to Dr. Leslie L. Robison, St. Jude Children's Research Hospital, Department of Epidemiology and Cancer Control, 262 Danny Thomas Place, Memphis, TN 38105 to inform the researcher of my decision. If I withdraw this authorization, the researcher may only use and disclose the protected health information already collected for his research study. No further health information about me will be collected by or disclosed to the researcher for this study.

7. **Potential for Re-disclosure.** Once my health information is disclosed under this authorization, there is a potential that it may be re-disclosed outside this study and no longer covered by this authorization. However, the research team and the St. Jude Institutional Review Board (the committee that reviews studies to be sure that the rights and safety of study participants are protected) are very careful to protect your privacy and limit the disclosure of identifying information about you.

   7A. Also, there are other laws that may require my individual health information to be disclosed for public purposes. Examples include potential disclosures if required for mandated reporting of abuse or neglect, judicial proceedings, health oversight activities and public-health measures.

This authorization expires at the end of the study.

I am the research participant or personal representative authorized to act on behalf of the participant.

I have read this information, and I will receive a copy of this authorization form after it is signed.

Printed name of research participant

Date of birth

_____ _____

Signature of research participant or research Participant's personal representative

Date

_____

Printed name of research participant's personal representative

_____

Description of personal representative's authority to act on behalf of the research participant

[1] HIPAA is the Health Insurance Portability and Accountability Act of 1996, a federal law related to privacy of health information. The Privacy Rule is 45 CFR Parts 160, 164.

Please! Do not mark below this line

INSTRUCTIONS FOR COMPLETING THE QUESTIONNAIRE

Please follow these rules in completing this questionnaire. If you have any questions about completing this questionnaire, please call 1-800-775-2167.

1. Use a black ballpoint pen or a number 2 black pencil. Do not use a felt-tip or roller-ball pen. These may cause smudging. If you must erase answers, erase them completely.
2. When marking boxes, make an x inside the box. (Example: ☒ Yes ☐ No ☐ Not sure)
3. Make no stray marks of any kind. Please keep the form as clean as possible.
4. Written responses must stay within the boxes provided:

CORRECT

Grape

INCORRECT

1. During this two year period, which of the following health care providers (excluding dentists) did you see or talk to for medical care? This includes routine and sick care. ***(Mark all that apply)***

- ☐ None → ***Skip to Question 4.***
- ☐ Physician (including Osteopath)
- ☐ Nurse Practitioner/Physician's Assistant
- ☐ Nurse
- ☐ Other

If Other, please describe.

2. Where did you receive your health care? ***(Mark all that apply)***

- ☐ Doctor's office
- ☐ Oncology (cancer) center or clinic
- ☐ Long-term follow-up clinic
- ☐ Other type of clinic
- ☐ Hospital
- ☐ Emergency room or urgent care center
- ☐ Other

If Other, please describe.

3. During this two year period, how many times did you see a physician?

- ☐ None
- ☐ 1-2 times
- ☐ 3-4 times
- ☐ 5-6 times
- ☐ 7-10 times
- ☐ 11-20 times
- ☐ More than 20 times

4. When was your MOST RECENT routine check-up where a doctor examined you and did tests to see if you had any health problems from your cancer or your cancer treatment?

- ☐ Less than 1 year ago
- ☐ 1-2 years ago
- ☐ More than 2 years but less than 5 years ago
- ☐ 5 or more years ago
- ☐ Never
- ☐ Don't know

5. When do you plan to have your NEXT visit with a doctor in order to examine you for any health problems from your cancer or your cancer treatment?

- ☐ Less than 1 year from now
- ☐ 1-2 years from now
- ☐ 3-4 years from now
- ☐ 5 or more years from now
- ☐ Never
- ☐ Don't know

Please! Do not mark below this line

6. **When did you have your MOST RECENT Pap smear (test for cancer of the cervix)?**

- ☐ Less than 1 year ago
- ☐ 1-2 years ago
- ☐ 3-4 years ago
- ☐ 5 or more years ago
- ☐ Never
- ☐ Don't know

7. **When did you have your MOST RECENT blood cholesterol test?**

- ☐ Less than 1 year ago
- ☐ 1-2 years ago
- ☐ 3-4 years ago
- ☐ 5 or more years ago
- ☐ Never
- ☐ Don't know

8. **When did you have your MOST RECENT blood pressure check?**

- ☐ Less than 1 year ago
- ☐ 1-2 years ago
- ☐ 3-4 years ago
- ☐ 5 or more years ago
- ☐ Never
- ☐ Don't know

9. **Do you currently take calcium supplements?**

☐ Yes ☐ No ☐ Don't know

10. **Do you currently smoke cigarettes?**

☐ No ☐ Yes

11. **How old were you when you had your first menstrual period?**

- ☐ 12 or younger
- ☐ 13
- ☐ 14
- ☐ 15 or older
- ☐ Not sure
- ☐ Never started my period → *Skip to Question 13.*

12. **Have your menstrual periods stopped permanently?** ***(Mark only one)***

- ☐ No
- ☐ Yes, natural menopause
- ☐ Yes, following a surgical procedure
- ☐ Yes, following radiation or chemotherapy
- ☐ Yes, don't know cause
- ☐ Not sure

If NO or NOT SURE, **when was the first day of your last period?**

☐☐ / ☐☐ / ☐☐☐☐

M M D D Y Y Y Y

If YES, **what was your age at your last period?** ☐☐ years old

13. **Are you currently taking a birth control pill or hormone replacement therapy, for example, Premarin, Prempro?**

☐ Yes ☐ No ☐ I am not sure

Name of medication:

14. **Are you currently taking anti-estrogen medicine, for example, Nolvadex (tamoxifen), or Evista (Raloxifene)?**

☐ Yes ☐ No ☐ I am not sure

Name of medication:

Please! Do not mark below this line

15. Have you ever given birth?

☐ No → *Skip to next section below.*

☐ Yes

16. How old were you when your first child was born?

☐☐ years old

17. How many children have you given birth to?

☐☐

The next few questions ask your views about your health care. There are no right or wrong answers-please answer how you feel.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Some people are very concerned about their health, while others are not as concerned. How concerned are you about your own health?	☐	☐	☐	☐	☐
2. Some people are very interested in going to the doctor for a general physical exam to check on their health, while others are not as interested. How interested are you about going to a doctor for "routine medical check-ups"?	☐	☐	☐	☐	☐
3. Some survivors of childhood cancer think that they can develop a health problem from their treatment several years later, while others do not think that they can ever have any more problems related to their previous cancer. How likely do you think it is in the future that you might develop a health problem related to your previous treatment for cancer?	☐	☐	☐	☐	☐
4. How important do you feel it is for you to have a routine check-up to see if you have any problems caused by the treatment of your previous cancer?	☐	☐	☐	☐	☐
5. Do you ever feel uncertain about your future health?	☐	☐	☐	☐	☐
6. Do you ever worry that your cancer will come back?	☐	☐	☐	☐	☐
7. Do you ever feel like you are different from others because you had cancer?	☐	☐	☐	☐	☐
8. Do you ever feel like you want to forget that you had cancer and just be like everyone else?	☐	☐	☐	☐	☐
9. Do you ever worry about being called a complainer or a hypochondriac?	☐	☐	☐	☐	☐
10. Do you ever worry that a problem with your health will be discovered if you go to a doctor for a routine check-up?	☐	☐	☐	☐	☐
11. Do you ever worry about getting another cancer in the future (different from your first cancer)?	☐	☐	☐	☐	☐
12. The thought of breast cancer scares me	☐	☐	☐	☐	☐
13. When I think of breast cancer, I feel anxious	☐	☐	☐	☐	☐

14. **Do you have a written summary of the treatment you received for your previous cancer?**

- ☐ No
- ☐ Yes
- ☐ Not sure

15. **Are you aware of the Children's Oncology Group screening recommendations for long-term survivors of childhood and adolescent cancers?**

- ☐ No
- ☐ Yes
- ☐ Not sure

The next series of questions are about breast cancer.

1. **Do you have any blood relatives who have been diagnosed with breast cancer?**

Mother	Sister(s)	Daughter(s)
☐ No	☐ No	☐ No
☐ Yes	☐ One	☐ One
☐ Not sure	☐ 2 or more	☐ 2 or more
	☐ Not sure	☐ Not sure

2. **Do you have any other relatives or close friends who have been diagnosed with breast cancer?**

- ☐ Yes
- ☐ No
- ☐ Not sure

The statements below describe beliefs that some people have about the risk of getting breast cancer. For each one, please mark the box that best describes what <u>you</u> think about the statement.

3. **Women who were treated with chemotherapy for childhood cancer are more likely to get breast cancer.**

- ☐ False
- ☐ True
- ☐ Not sure

4. **Women who were treated with radiation to the chest or breast area for childhood cancer are more likely to get breast cancer.**

- ☐ False
- ☐ True
- ☐ Not sure

5. **The <u>average</u> lifetime risk for breast cancer for women is 1 in 9, or 11 percent. We are interested in what you think about your own breast cancer risk. How would you estimate your own chance of getting breast cancer in the future?**

- ☐ Much more than the average woman
- ☐ More than the average woman
- ☐ Same as the average woman
- ☐ Less than the average woman
- ☐ Much less than the average woman

Continue on next page.

The next questions ask your views about breast cancer screening tests and about your history.

1. **Have you heard of mammography for breast cancer screening?**
   - ☐ Yes
   - ☐ No
   - ☐ Not sure

2. **At what age should <u>women like you</u> begin getting a mammogram?**
   - ☐☐ yrs
   - ☐ Not sure

3. **How frequently should <u>women like you</u> get a mammogram?**
   - ☐ Every 6 months
   - ☐ Every year
   - ☐ Every 1-2 years
   - ☐ Every 2-5 years
   - ☐ I am not supposed to get a mammogram yet
   - ☐ When my doctor tells me to

4. **Have you EVER had a mammogram?**
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

   Skip to Question 11

5. **About how old were you when you had your first mammogram?**
   - ☐☐ years old
   - ☐ Don't know/don't remember

6. **When did you have your MOST RECENT mammogram? Was it:**
   - ☐ Less than 1 year ago
   - ☐ 1-2 years ago
   - ☐ 3-4 years ago
   - ☐ 5 or more years ago
   - ☐ Don't know

7. **What was the MAIN reason you had this mammogram?** ***(Please check only one)***
   - ☐ Part of a routine physical exam/screening test
   - ☐ Because of a specific breast problem

8. **Have you EVER had a mammogram where the results were not normal?**
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

   Skip to Question 11

9. **If you have ever had an abnormal mammogram, when was it?**
   - ☐ Less than 1 year ago
   - ☐ 1-2 years ago
   - ☐ 3-4 years ago
   - ☐ 5 or more years ago
   - ☐ Don't know

10. **Because of these results, what additional tests or surgery did you have?** ***(Mark all that apply)***
    - ☐ None
    - ☐ Another mammogram
    - ☐ Ultrasound of the breast
    - ☐ MRI of the breast
    - ☐ Needle biopsy (needle inserted into a breast lump)
    - ☐ Tumor or lump was removed (lumpectomy)
    - ☐ Breast removed/mastectomy

Please! Do not mark below this line

If you have had a mammogram in the past two years,

→ *Skip to Question 12*

11. If you HAVE NOT HAD a mammogram in the LAST TWO YEARS, we are interested in the most important reasons. How important were each of the following reasons for not having a mammogram?

Mark only one answer for each problem and try not to skip any items.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
a. No reason/never thought of it	☐	☐	☐	☐	☐
b. Didn't need it/didn't know I needed this type of test	☐	☐	☐	☐	☐
c. I'm too young	☐	☐	☐	☐	☐
d. Doctor didn't order it/didn't say I needed it	☐	☐	☐	☐	☐
e. Haven't had any problems	☐	☐	☐	☐	☐
f. Put it off/didn't get around to it.	☐	☐	☐	☐	☐
g. Too busy/no time	☐	☐	☐	☐	☐
h. I already have too many other medical appointments	☐	☐	☐	☐	☐
i. Too expensive/no insurance/cost.	☐	☐	☐	☐	☐
j. Too painful, unpleasant, or embarrassing	☐	☐	☐	☐	☐
k. The results would make me too anxious or worried.	☐	☐	☐	☐	☐
l. Don't have a doctor	☐	☐	☐	☐	☐
m. Other reason.	☐	☐	☐	☐	☐

If Other reason, please specify:

12. Do you plan to have a mammogram in the future?

- ☐ Yes
- ☐ Not planning to have one
- ☐ Don't know

***IF YES,* when?**

- ☐ Within the next 6 months
- ☐ In 6 months to 1 year
- ☐ In 1-2 years
- ☐ In 3-4 years
- ☐ In 5 or more years
- ☐ When my doctor recommends
- ☐ When I have a symptom or breast problem
- ☐ Don't know

13. In the PAST YEAR has a doctor or other health professional RECOMMENDED that you have a mammogram?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Did not see a doctor in the past 12 months

IF YES,* what type of doctor or health care professional? *(Mark all that apply)

- ☐ Primary care physician (family physician, general internist) or primary care nurse practitioner, physician assistant
- ☐ Obstetrician/gynecologist
- ☐ Pediatric oncologist
- ☐ Other oncologist
- ☐ Other

If Other, please specify:

14. If you wanted to get a mammogram, would your doctor order one?

☐ Yes ☐ No ☐ Not sure

Please! Do not mark below this line

The following statements are about your views on mammograms.

	Strongly disagree	Disagree	Don't agree or disagree	Agree	Strongly agree
1. If I have a breast exam from a doctor or nurse, I don't need to have a mammogram	☐	☐	☐	☐	☐
2. Those people who are close to me will benefit if I have a mammogram	☐	☐	☐	☐	☐
3. Mammograms have a high chance of leading to breast surgery that is not needed	☐	☐	☐	☐	☐
4. I would be more likely to have a mammogram if my doctor told me how important it was	☐	☐	☐	☐	☐
5. Having a mammogram every year will give me a feeling of control over my health	☐	☐	☐	☐	☐
6. Once you have a couple of mammograms that are normal, you don't need to have any more for a few years	☐	☐	☐	☐	☐
7. Regular mammograms give you peace of mind about your health	☐	☐	☐	☐	☐
8. Mammograms are necessary even when there is no history of breast problems in a family	☐	☐	☐	☐	☐
9. If a mammogram finds something, then whatever is there will be too far along to do anything about it anyway	☐	☐	☐	☐	☐
10. Mammograms are most helpful when you have one every year	☐	☐	☐	☐	☐
11. I would probably not have a mammogram if my doctor seemed to doubt that I really needed one	☐	☐	☐	☐	☐
12. If I eat a healthy diet, I will lower my risk of getting cancer far enough that I probably do not need to have a mammogram	☐	☐	☐	☐	☐
13. I would probably not have a mammogram unless I had some breast symptoms or discomfort	☐	☐	☐	☐	☐
14. I do not feel that I have enough information to make a decision on whether or not to have a mammogram	☐	☐	☐	☐	☐

The following statements are about getting a mammogram if you wanted to.

1. You could arrange transportation to get a mammogram	☐	☐	☐	☐	☐
2. You could arrange other things in your life to have a mammogram	☐	☐	☐	☐	☐
3. You could find a way to pay for a mammogram	☐	☐	☐	☐	☐
4. You could make an appointment for a mammogram	☐	☐	☐	☐	☐
5. You could find a place to have a mammogram	☐	☐	☐	☐	☐
6. You could discuss having a mammogram with your health care provider even if (s)he does not bring it up	☐	☐	☐	☐	☐

Please! Do not mark below this line

The following questions ask about Magnetic Resonance Imagery (MRI) of the breast.

1. **Have you heard of getting an MRI for breast cancer screening?**
   - ☐ Yes
   - ☐ No → *Skip to Question 4.*
   - ☐ Not sure

2. **At what age should <u>women like you</u> begin getting a breast MRI?**
   - ☐☐ yrs
   - ☐ Never
   - ☐ Not sure

3. **How frequently should <u>women like you</u> get a breast MRI?**
   - ☐ Never
   - ☐ Every 6 months
   - ☐ Every year
   - ☐ Every 1-2 years
   - ☐ Every 2-5 years
   - ☐ I am not supposed to get a breast MRI
   - ☐ When my doctor tells me to

4. **Have you EVER had a breast MRI?**
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

   Skip to Question 11

5. **About how old were you when you had your first breast MRI?**
   - ☐☐ years old
   - ☐ Don't know/don't remember

6. **When did you have your MOST RECENT breast MRI? Was it:**
   - ☐ Less than 1 year ago
   - ☐ 1-2 years ago
   - ☐ 3-4 years ago
   - ☐ 5 or more years ago
   - ☐ Don't know

7. **What was the MAIN reason you had this breast MRI?** ***(Please check only one)***
   - ☐ Part of a routine physical exam/screening test
   - ☐ Because of a specific breast problem

8. **Have you EVER had a breast MRI where the results were not normal?**
   - ☐ Yes
   - ☐ No
   - ☐ Don't know

   Skip to Question 11

9. **If you have ever had an abnormal breast MRI, when was it?**
   - ☐ Less than 1 year ago
   - ☐ 1-2 years ago
   - ☐ 3-4 years ago
   - ☐ 5 or more years ago
   - ☐ Don't know

10. **Because of these results, what additional tests or surgery did you have?** ***(Mark all that apply)***
    - ☐ None
    - ☐ Another MRI of the breast
    - ☐ Mammogram
    - ☐ Ultrasound of the breast
    - ☐ Needle biopsy (needle inserted into a breast lump)
    - ☐ Tumor or lump was removed (lumpectomy)
    - ☐ Breast removed/mastectomy

Please! Do not mark below this line

If you have had a breast MRI in the past two years,

→ *Skip to Question 12*

11. If you HAVE NOT HAD a breast MRI in the LAST TWO YEARS, we are interested in the most important reasons. How <u>important</u> were each of the following reasons for not having a breast MRI?

Mark only one answer for each problem and try not to skip any items.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
a. No reason/never thought of it	☐	☐	☐	☐	☐
b. Didn't need it/didn't know I needed this type of test	☐	☐	☐	☐	☐
c. I'm too young	☐	☐	☐	☐	☐
d. Doctor didn't order it/didn't say I needed it	☐	☐	☐	☐	☐
e. Haven't had any problems	☐	☐	☐	☐	☐
f. Put it off/didn't get around to it.	☐	☐	☐	☐	☐
g. Too busy/no time	☐	☐	☐	☐	☐
h. I already have too many other medical appointments	☐	☐	☐	☐	☐
i. Too expensive/no insurance/cost.	☐	☐	☐	☐	☐
j. Too painful, unpleasant, or embarrassing	☐	☐	☐	☐	☐
k. The results would make me too anxious or worried.	☐	☐	☐	☐	☐
l. Don't have a doctor	☐	☐	☐	☐	☐
m. Other reason.	☐	☐	☐	☐	☐

If Other reason, please specify:

12. Do you plan to have a breast MRI in the future?

- ☐ Yes
- ☐ Not planning to have one
- ☐ Don't know

***IF YES,* when?**

- ☐ Within the next 6 months
- ☐ In 6 months to 1 year
- ☐ In 1-2 years
- ☐ In 3-4 years
- ☐ In 5 or more years
- ☐ When my doctor recommends
- ☐ When I have a symptom or breast problem
- ☐ Don't know

13. In the PAST YEAR has a doctor or other health professional RECOMMENDED that you have a breast MRI?

- ☐ Yes
- ☐ No
- ☐ Don't know
- ☐ Did not see a doctor in the past 12 months

14. If you wanted to get a breast MRI, would your doctor order one?

- ☐ Yes
- ☐ No
- ☐ Not sure

Please! Do not mark below this line

The next several statements are about MRI as a procedure to examine your breasts.

	Strongly disagree	Disagree	Don't agree or disagree	Agree	Strongly agree
1. A breast MRI will not benefit my health beyond what a mammogram can do	☐	☐	☐	☐	☐
2. An MRI can find things in my breasts that a mammogram might miss	☐	☐	☐	☐	☐
3. Having a breast MRI takes too long for the time I have available	☐	☐	☐	☐	☐
4. I do not want to be in a confined "tube" in order to get a breast MRI	☐	☐	☐	☐	☐
5. The time needed to have a breast MRI is worth it for the potential benefits	☐	☐	☐	☐	☐
6. I do not feel that I have enough information to make a decision on whether or not to have a breast MRI	☐	☐	☐	☐	☐
7. If I have a normal mammogram, I do not need to have a breast MRI	☐	☐	☐	☐	☐

1. In general, would you say your health is:

- ☐ Excellent
- ☐ Very good
- ☐ Good
- ☐ Fair
- ☐ Poor

2. Do you have any chronic health problems (that have lasted longer than six months)?

- ☐ No → *Skip to next page.*
- ☐ Yes

If Yes, please describe your main chronic health problem:

3. How would you rate your <u>main</u> chronic health problem?

- ☐ Mild - Do not take any medications and it does not affect my daily life.
- ☐ Moderate - Take medications regularly or have to go to the doctor more often for testing or monitoring.
- ☐ Severe - Has significantly changed my daily activities and/or requires close monitoring by a doctor.
- ☐ Life-threatening

Continue on next page.

Please! Do not mark below this line

Questions 1 to 18 relate to the past 7 days.

Below is a list of problems people sometimes have. Please read each one carefully and mark the box that best describes how much that problem has distressed or bothered you during the past 7 days including today.

Mark only one answer for each problem and try not to skip any items.

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Nervousness or shaking inside	☐	☐	☐	☐	☐
2. Faintness or dizziness	☐	☐	☐	☐	☐
3. Pains in heart or chest	☐	☐	☐	☐	☐
4. Thoughts of ending your life	☐	☐	☐	☐	☐
5. Suddenly scared for no reason	☐	☐	☐	☐	☐
6. Feeling lonely	☐	☐	☐	☐	☐
7. Feeling blue	☐	☐	☐	☐	☐
8. Feeling no interest in things	☐	☐	☐	☐	☐
9. Feeling fearful	☐	☐	☐	☐	☐
10. Nausea or upset stomach	☐	☐	☐	☐	☐
11. Trouble getting your breath	☐	☐	☐	☐	☐
12. Numbness or tingling in parts of your body	☐	☐	☐	☐	☐
13. Feeling hopeless about the future	☐	☐	☐	☐	☐
14. Feeling weak in parts of your body	☐	☐	☐	☐	☐
15. Feeling tense or keyed up	☐	☐	☐	☐	☐
16. Spells of terror or panic	☐	☐	☐	☐	☐
17. Feeling so restless you couldn't sit still	☐	☐	☐	☐	☐
18. Feelings of worthlessness	☐	☐	☐	☐	☐

By marking one box in each group below, please indicate which statements best describe your own health state today.

1. Mobility

- ☐ I have no problems in walking about
- ☐ I have some problems in walking about
- ☐ I am confined to bed

2. Self-Care

- ☐ I have no problems with self-care
- ☐ I have some problems washing or dressing myself
- ☐ I am unable to wash or dress myself

3. Usual Activities (e.g. work, study, housework, family or leisure activities)

- ☐ I have no problems with performing my usual activities
- ☐ I have some problems with performing my usual activities
- ☐ I am unable to perform my usual activities

4. Pain/Discomfort

- ☐ I have no pain or discomfort
- ☐ I have moderate pain or discomfort
- ☐ I have extreme pain or discomfort

1. To the nearest inch, what is your current height without shoes?

☐ ☐☐ Feet Inches

2. To the nearest pound, what is your current weight without shoes?

☐☐☐ Pounds

Please! Do not mark below this line

3. Do you currently have health insurance coverage?

- ☐ Canadian resident
- ☐ No
- ☐ Yes

***IF YES,* do you have a large deductible with your health insurance plan?**

☐ Yes ☐ No ☐ Don't know

4. What is your current employment status? Include unpaid work in the family business or farm.
(Mark all that apply)

- ☐ Working full-time (30 or more hours per week)
- ☐ Working part-time (less than 30 hours per week)
- ☐ Caring for home or family (not seeking paid work)
- ☐ Unemployed and looking for work
- ☐ Unable to work due to illness or disability
- ☐ Retired
- ☐ Student
- ☐ Other

If Other, please describe.

5. What is your current living arrangement?
(Mark all that apply)

- ☐ Live with spouse/partner
- ☐ Live with parent(s)
- ☐ Live with roommate(s)
- ☐ Live with brother(s) and/or sister(s)
- ☐ Live with other relative(s) (not including minor children)
- ☐ Live alone
- ☐ Other

If Other, please specify:

6. Which of these possibilities best describes your current marital status?

- ☐ Single
- ☐ Married
- ☐ Living with partner as married
- ☐ Widowed
- ☐ Divorced
- ☐ Separated or no longer living as married

7. What is the highest grade or level of schooling you have now completed?

- ☐ 1-8 years (grade school)
- ☐ 9-12 years (high school) but did not graduate
- ☐ Completed high school/GED
- ☐ Training after high school, other than college
- ☐ Some college
- ☐ College graduate
- ☐ Post graduate level
- ☐ Other

If Other, please describe.

8. Over the last year, what was the total income of the household you live in?

- ☐ Less than $20,000
- ☐ $20,000 - $39,999
- ☐ $40,000 - $59,999
- ☐ $60,000 - $79,999
- ☐ $80,000 - $99,999
- ☐ Over $100,000
- ☐ Don't know

Please! Do not mark below this line

We would like to interview you by telephone in the next several weeks. The interview should take about 30 minutes. Please describe time frames (day of week, time of day) during which you may be available. For example, you might say any weekday morning before 10 am; any weekday evening after 6 pm; any Saturday morning; anytime on a weekend; any Monday, Wednesday, or Friday after 3 pm; any time on any weekday except Wednesdays; weekend evenings only.

Preferred Time Frame for Telephone Interview:

Please provide the following contact numbers and e-mail address and check which one you would prefer us to use:

☐ **Home telephone number:** ( ) -

☐ **Cell telephone number:** ( ) -

☐ **Work telephone number:** ( ) -

☐ **E-mail address:**

We have your current address, phone, and email address as:

Is this information correct, or are you planning on moving in the next 6 months?

☐ Correct ☐ Not correct ☐ Moving

If this information is not correct, please give us your correct contact information:

Address	City
State	Zip Code
Phone Number	Email address

Please provide the name and address of someone who could give us your new address should you move. We will contact this person only if we are unable to reach you at your home address.

Name	Relationship to you
Address	City
State	Zip Code
Phone Number	Email address

Please! Do not mark below this line