CAROLINA ENDOMETRIAL CANCER STUDY

University of North Carolina at Chapel Hill
Lineberger Comprehensive Cancer Center – North
1700 Martin Luther King Jr Blvd
CB# 7294 | Room 323
Chapel Hill, NC 27599-7294

FOLLOW-UP #02

MAIL-IN SURVEY

*Same as Mail-In version, just changed cover sheet, & footer.

SECTION A: INTRODUCTORY STATEMENT

Thank you for agreeing to share with us more about your endometrial cancer experience. All the information you provide today will be kept confidential. You can choose not to answer any questions you do not want to answer. We will send you $40 within four weeks of completing this follow-up survey.

SECTION B: GIFT CARD / ADDRESS INFORMATION

First, I'd like to verify phone information so that we may process gift card payments and confirm any address changes since our last contact.

B1a. The preferred number we have recorded for you is **«primary_phone»**. Is this correct?

- ■ Yes ➔ **SKIP TO B2a**
- ■ No

B1b. What is your preferred phone number? ____ ____ ____ - ____ ____ ____ - ____ ____ ____ ____

B1c. Is this number a cell, home or work phone?

- ■ Cell
- ■ Home
- ■ Work
- ■ Other, specify: _____

B2a. The mailing address we have on file for you is:

«mail_addr1»
«mail_addr2»
«mail_city», «mail_state» «mail_zip»

Is this your preferred mailing address?

- ■ Yes ➔ **SKIP TO B3a**
- ■ No

B2b. What is your preferred mailing address?

_____

_____

_____

B3a. Is the address listed above your physical / residential address?

- ■ Yes ➔ **SKIP TO B3c**
- ■ No

B3b. What is your current physical / residential address?

_____

_____

_____

B3c. When did you begin living at this address?

____ ____ / ____ ____ ____ ____
Month Year

B4a. Have you lived at any other physical / residential addresses since we last contacted you?

- ■ Yes
- ■ No ➔ **SKIP TO Section C**

B4b. Please list any additional physical / residential addresses since we last contacted you:

Address 1:

_____

_____

_____

From: ____ ____ / ____ ____ ____ ____ To: ____ ____ / ____ ____ ____ ____
Month Year Month Year

Address 2:

_____

_____

_____

From: ____ ____ / ____ ____ ____ ____ To: ____ ____ / ____ ____ ____ ____
Month Year Month Year

Address 3:

_____

_____

_____

From: ____ ____ / ____ ____ ____ ____ To: ____ ____ / ____ ____ ____ ____
Month Year Month Year

SECTION C: TREATMENT / HEALTH CARE PROVIDER UPDATES

At the previous follow-up, you were asked to provide information about any treatments you had for endometrial cancer up to that point in time. We would like to update your treatment information as of today.

C1. Since our last contact, or within the last 12 months, are there any health care providers who have provided additional treatment or follow-up care for your endometrial cancer? This may include follow-up office visits with your OB/GYN, surgeon, oncologist, or primary care physician:

- ■ Yes
- ■ No ➔ **SKIP TO C4a**

C2a. Since our last contact, or within the last 12 months, have you had a recurrence of your endometrial cancer? In other words, has your cancer come back in the same place or spread to another part of the body?

- ■ Yes
- ■ No ➔ **SKIP TO C3**
- ■ Don't Know ➔ **SKIP TO C3**

C2b. When was the recurrence diagnosed?

____ ____ / ____ ____ ____ ____
Month Year

C2c. Please provide any information you can about the physician who first told you about the recurrence:

Name: _____

Practice/Clinic/Hospital Name: _____

Street Address: _____

City, State, Zip: _____

Telephone: ____ ____ ____ - ____ ____ ____ - ____ ____ ____ ____

C3. Please provide any information you can about health care providers who have provided additional treatment or follow-up care for your endometrial cancer. If included with this mailing, it may help to review the *Health Care Providers Report* when completing this question.

Physician 1 Information:

Name: _____

Practice/Clinic/Hospital Name: _____

Street Address: _____

City, State, Zip: _____

Telephone: ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

What treatment did you receive from this provider?

_____

Approximately when did this treatment or follow up care occur?

_____

Physician 2 Information (as needed):

Name: _____

Practice/Clinic/Hospital Name: _____

Street Address: _____

City, State, Zip: _____

Telephone: ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

What treatment did you receive from this provider?

_____

Approximately when did this treatment or follow up care occur?

_____

Physician 3 Information (as needed):

Name:	
Practice/Clinic/Hospital Name:	
Street Address:	
City, State, Zip:	
Telephone:	___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___
What treatment did you receive from this provider?	
Approximately when did this treatment or follow up care occur?	

C4a. Since our last contact, or within the last 12 months, have you been diagnosed with any other cancer?

- ■ Yes
- ■ No ➔ **SKIP TO C5**
- ■ Don't Know ➔ **SKIP TO C5**

C4b. When was the cancer diagnosed?

___ ___ / ___ ___ ___ ___
Month Year

C4c. What type of cancer was diagnosed? _____

C4d. Please provide any information you can about the physician who first told you about the new cancer:

Name: _____

Practice/Clinic/Hospital Name: _____

Street Address: _____

City, State, Zip: _____

Telephone: ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

C5. We may want to request updated copies of your medical records and/or obtain tumor tissue. To do so, we would need to obtain newly signed consents. Payment for receipt of newly signed consents is $15 for medical records and HIPAA authorizations and an additional $15 for tumor tissue consent. If we send you new consents and you complete them, do you grant permission for us to contact your providers for medical records and/or tumor tissue?

- ■ Yes, you may contact all providers listed.
- ■ No, you may not contact any of the providers listed.
- ■ You may contact all but these providers. Specify: _____

SECTION D: MEDICAL HISTORY

This section asks about updates to your personal medical history.

Since our last contact, or within the last 12 months, have you been **newly diagnosed** by a medical provider as having:

D1.	Heart attack (myocardial infarction)?	■ Yes	■ No
D2.	Heart disease?	■ Yes	■ No
D3.	Heart failure?	■ Yes	■ No
D4.	Peripheral vascular disease or deep vein thrombosis (blocked arteries/veins in your arms/legs)?	■ Yes	■ No
D5.	Chronic obstructive lung disease (COPD)?	■ Yes	■ No
D6	Chronic bronchitis?	■ Yes	■ No
D7.	Emphysema?	■ Yes	■ No
D8.	Glaucoma?	■ Yes	■ No
D9.	Stomach ulcers proven by a test?	■ Yes	■ No
D10a.	Other stomach or intestinal disorders?	■ Yes	■ No
D10b.	If yes, please specify: _____		
D11.	Liver disease?	■ Yes	■ No
D12.	A stroke/mini-stroke?	■ Yes	■ No
D13.	Hemiplegia (weakness/paralysis of arms/legs)?	■ Yes	■ No
D14.	Dementia (e.g. Alzheimer's)?	■ Yes	■ No
D15.	HIV/AIDS?	■ Yes	■ No
D16.	Hypertension/High blood pressure?	■ Yes	■ No
D17.	High Cholesterol?	■ Yes	■ No
D18.	Anxiety?	■ Yes	■ No
D19.	Depression?	■ Yes	■ No

D20a.	Serious kidney problems?	■ Yes	■ No
D20b.	If yes, have you ever required dialysis?	■ Yes	■ No
D21.	Rheumatoid arthritis?	■ Yes	■ No
D22.	Osteoporosis	■ Yes	■ No
D23a.	Other joint/bone problems?	■ Yes	■ No
D23b.	If yes, please specify: _____		
D24a.	Diabetes?	■ Yes	■ No
D24b.	If yes: What type? ■ Type I ■ Type II ■ Other/Don't Know		
D24c.	Have you ever had eye problems due to diabetes?	■ Yes	■ No
D24d.	Have you ever had kidney problems due to diabetes?	■ Yes	■ No
D25a.	Hepatitis?	■ Yes	■ No
D25b.	If yes, what type? ■ A ■ B ■ C	Other, specify: _____	

D26a. Are you taking any prescription medications for any of the conditions in questions **D1-D25b**?

■ Yes

■ No ➔ **SKIP TO D27.**

D26b. What prescription medications are you taking for the conditions in questions **D1-D25b**?

Medication:	Condition(s):
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

D27. Including any prescription medications you may be taking for other conditions, what is the total number of prescription medications you currently take?

____ ____ total prescription medications

SECTION E: LIFESTYLE AND PREVENTATIVE HEALTH CARE

The next questions ask about your current physical activity.

During a typical week, how many times on average do you do the following kinds of exercise for **more than 15 minutes** during your free time? **Please do not include work or household activities:**

E1.	**Strenuous exercise** *- heart beats rapidly*	*e.g., running, jogging, hockey, football, soccer, squash, basketball, cross country skiing, judo, roller skating, vigorous swimming, vigorous long-distance bicycling*	_____ time(s) per week _____ average minutes each time you exercised
E2.	**Moderate exercise** *- not exhausting*	*e.g., fast walking, baseball, tennis, easy bicycling, volleyball, badminton, easy swimming, alpine skiing, popular and folk dancing*	_____ time(s) per week _____ average minutes each time you exercised
E3.	**Mild exercise** **-** *minimal effort*	*e.g., yoga, archery, fishing from riverbank, bowling, horseshoes, golf, snowmobiling, easy walking*	_____ time(s) per week _____ average minutes each time you exercised

E4 Over the past month, how would you rate your 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 bed or chair less than half the day
- ■ Able to do little activity and spend most of the day in bed or chair
- ■ Pretty much bed ridden, rarely out of bed
- ■ Unknown

E5. Does your health limit you in walking one block?

- ■ Not limited at all
- ■ Limited a little
- ■ Limited a lot
- ■ Unknown

The next questions ask about height and weight.

E6. What is your current height? ____ feet ____ ____ inches

E7. What is your current weight? ____ ____ ____ pounds

E7b. Over the past 6 months, have you lost weight without meaning to?

- ■ Yes
- ■ No ➔ **SKIP TO E8**
- ■ Don't Know ➔ **SKIP TO E8**

E7c. If you answered yes to question 7b., how much weight have you lost without meaning to in the past 6 months?

____ ____ ____ pounds

E8. As compared to your normal food intake, how would you rate your food intake during the past month:

- ◯ Unchanged
- ◯ More than usual
- ◯ Less than usual
- ◯ Unknown

This section asks about health care and wellness.

E9. Since our last contact, or within the last 12 months, have you:

Seen a regular doctor for a physical examination or check-up?	◯ Yes	◯ No
Had an eye exam to check your vision?	◯ Yes	◯ No
Seen a dentist or dental hygienist to check your teeth?	◯ Yes	◯ No
Had a Flu Vaccine?	◯ Yes	◯ No
Had a colonoscopy or sigmoidoscopy, that is, an examination with a lighted tube to check for signs of cancer in your rectum or colon?	◯ Yes	◯ No
Had a FIT (Fecal Immunochemical Test), that is, a test for blood in the stool to check for signs of cancer in your rectum or colon?	◯ Yes	◯ No
Had a mammogram, that is, an examination with an x-ray image to check for signs of cancer in your breasts?	◯ Yes	◯ No

SECTION F: COVID-19

This section asks about experiences related to the COVID-19 pandemic.

F1. Have you had any test for COVID-19, including a test that collected a nasal swab, or blood sample, or a spit saliva sample?

- ◯ Yes
- ◯ No

F2. Have you ever tested positive for COVID-19?

- ◯ Yes
- ◯ No
- ◯ Waiting for results

F3. Have you received a COVID-19 vaccine?

- ◯ Yes
- ◯ No

SECTION G: CONCENTRATION AND FEELINGS

These next questions ask about your ability to think.

Please respond to each question or statement by marking one circle per row.

	In the past 7 days...	**Never**	**Rarely (Once)**	**Sometimes (Two or three times)**	**Often (About once a day)**	**Very often (Several times a day)**
G1.	My thinking has been slow.....	◯	◯	◯	◯	◯
G2.	It has seemed like my brain was not working as well as usual.....	◯	◯	◯	◯	◯
G3.	I have had to work harder than usual to keep track of what I was doing.....	◯	◯	◯	◯	◯
G4.	I have had trouble shifting back and forth between different activities that require thinking	◯	◯	◯	◯	◯
G5.	I have had trouble concentrating	◯	◯	◯	◯	◯
G6.	I have had to work really hard to pay attention or I would make a mistake	◯	◯	◯	◯	◯
G7.	I have had trouble forming thoughts.....	◯	◯	◯	◯	◯
G8.	I have had trouble adding or subtracting numbers in my head	◯	◯	◯	◯	◯

These next questions ask about your feelings during the past week.

Please respond to each question or statement by marking one circle per row.

	In the past 7 days…	Never	Rarely	Sometimes	Often	Always
G9.	I felt fearful.....	○	○	○	○	○
G10.	I found it hard to focus on anything other than my anxiety.....	○	○	○	○	○
G11.	My worries overwhelmed me.....	○	○	○	○	○
G12.	I felt uneasy……...	○	○	○	○	○
G13.	I felt worthless	○	○	○	○	○
G14.	I felt helpless	○	○	○	○	○
G15.	I felt depressed	○	○	○	○	○
G16.	I felt hopeless	○	○	○	○	○

Below is a list of statements that other people with your illness have said are important**. Please mark one circle per line to indicate your response as it applies to the past 7 days.**

		Not at all	A little bit	Some-what	Quite a bit	Very much
G17.	I feel peaceful…	■	■	■	■	■
G18.	I have a reason for living…	■	■	■	■	■
G19.	My life has been productive	■	■	■	■	■
G20.	I have trouble feeling peace of mind…	■	■	■	■	■
G21.	I feel a sense of purpose in my life…	■	■	■	■	■
G22.	I am able to reach down deep into myself for comfort…	■	■	■	■	■
G23	I feel a sense of harmony within myself…	■	■	■	■	■
G24.	My life lacks meaning and purpose…	■	■	■	■	■
G25.	I find comfort in my faith or spiritual beliefs…	■	■	■	■	■
G26.	I find strength in my faith or spiritual beliefs…	■	■	■	■	■
G27.	My illness has strengthened my faith or spiritual beliefs…	■	■	■	■	■
G28.	I know that whatever happens with my illness, things will be okay…	■	■	■	■	■

SECTION H: QUALITY OF LIFE AND DAILY ACTIVITIES

This section asks about your physical well-being and quality of life since our last contact, or within the last 12 months.

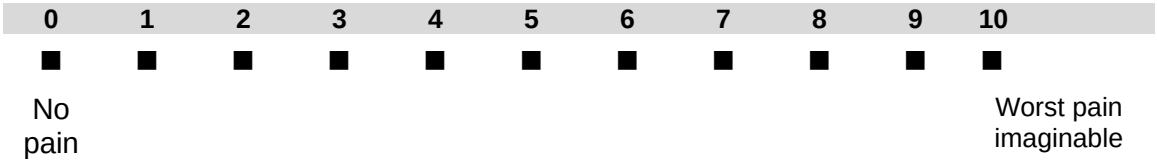
		Excellent	Very good	Good	Fair	Poor
H1.	In general, would you say your health is:	■	■	■	■	■
H2.	In general, would you say your quality of life is:.....	■	■	■	■	■
H3.	In general, how would you rate your physical health?	■	■	■	■	■
H4.	In general, how would you rate your mental health, including your mood and your ability to think?	■	■	■	■	■
H5.	In general, how would you rate your satisfaction with your social activities and relationships?	■	■	■	■	■
H6.	In general, please rate how well you carry out your usual social activities and roles. This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.	■	■	■	■	■

		Completely	Mostly	Moderately	A little	Not at all
H7.	To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	■	■	■	■	■

		Never	Rarely	Some-times	Often	Always
H8.	**In the past 7 days,** how often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	■	■	■	■	■

		None	Mild	Moderate	Severe	Very Severe
H9.	**In the past 7 days,** how would you rate your fatigue on average?	■	■	■	■	■

H10. In the past 7 days, how would you rate your pain on average?



H11. How many times have you fallen in the last 6 months?

- ■ 1 or more
- ■ None
- ■ Unknown

H12. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities for example, visiting with friends, relatives, etc.?

- ■ All of the time
- ■ Most of the time
- ■ Some of the time
- ■ A little of the time
- ■ None of the time
- ■ Unknown

H13. How is your eyesight including glasses or contacts if needed?

- ■ Excellent
- ■ Good
- ■ Fair
- ■ Poor
- ■ Totally Blind
- ■ Unknown

H14. How is your hearing-- with a hearing aid, if needed?

- ■ Excellent
- ■ Good
- ■ Fair
- ■ Poor
- ■ Totally Deaf
- ■ Unknown

This section is about activities of daily living, things that we all need to do as part of our daily lives. We would like to know if you can do these activities without any help at all, or if you need some help to do them, or if you can't do them at all.

H15. Can you get to places out of walking distance ...

- ■ Without help, for example, drive your own car, or travel alone on buses, or taxis.
- ■ With some help, for example, need someone to help you or go with you when traveling.
- ■ Are you unable to travel unless emergency arrangements are made for a specialized vehicle like an ambulance?
- ■ Unknown

H16. Can you go shopping for groceries or clothes…

- ■ Without help, for example, taking care of all shopping needs yourself, assuming you had transportation;
- ■ With some help, for example, need someone to go with you on all shopping trips
- ■ Are you completely unable to do any shopping?
- ■ Unknown

H17. Can you prepare your own meals ...

- ■ Without help, for example, you can plan and cook full meals yourself;
- ■ With some help, for example, you can prepare some things but unable to cook full meals yourself;
- ■ Are you completely unable to prepare any meals?
- ■ Unknown

H18. Can you do your housework ...

- ■ Without help, for example, you can clean floors, etc.;
- ■ With some help, for example, you can do light housework but need help with heavy work;
- ■ Are you completely unable to do any housework?
- ■ Unknown

H19. Can you take your own medicine ...

- ■ Without help, for example, you can take your own medicine in the right doses at the right time;
- ■ With some help, for example, you are able to take medicine if someone prepares it for you and/or reminds you to take it;
- ■ Are you completely unable to take your medicines?
- ■ Unknown

H20. Can you handle your own money ...

- ■ without help, for example, you are able to write checks, pay bills, etc.;
- ■ with some help, for example, you are able to manage day-to-day buying but need help with managing your checkbook and paying your bills;
- ■ are you completely unable to handle money?
- ■ Unknown

H21. Can you dress and undress yourself ...

- ■ without help (able to pick out clothes, dress and undress yourself))

- ■ with some help
- ■ are you completely unable to dress and undress yourself?
- ■ Unknown

H22. Can you get in and out of bed…

- ■ without help or aids
- ■ with some help (either from a person or with the aid of some device)
- ■ are you totally dependent on someone else to lift you?
- ■ Unknown

H23. Can you take a bath or shower ...

- ■ without help
- ■ with some help (need help getting in and out of the tub, or need special attachments on the tub)
- ■ are you completely unable to bathe yourself?
- ■ Unknown

SECTION I: ACCESS TO MEDICAL CARE / FINANCIAL SITUATION

This section asks about your work. If you have more than one job, please use the job that you spent more hours at.

I1. Which of the following best describes your current employment status? Choose one:

- ■ Employed full time
- ■ Employed part time
- ■ Not employed, but looking for work
- ■ Not employed – not retired, disabled, or looking for work
- ■ Retired
- ■ Disabled, not able to work
- ■ Other, specify: _____

I2. What is your present marital status?

- ■ Never married or partnered
- ■ Married or partnered
- ■ Widowed
- ■ Separated, divorced, or no longer partnered

I3. This year, what will be your total household income range, before taxes? Choose one:

- ■ Less than $5,000
- ■ $5,000 to $10,000
- ■ $10,001 to $20,000
- ■ $20,001 to $30,000
- ■ $30,001 to $40,000
- ■ $40,001 to $50,000
- ■ $50,001 to $100,000
- ■ $100,001 or more
- ■ Prefer not to answer

This section asks about access to medical care and how you feel about your financial situation.

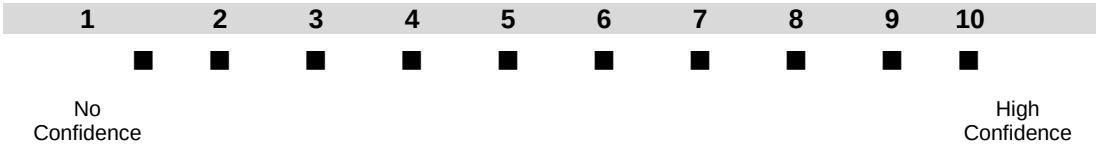
I4. What type(s) of health insurance do you have now? Select all that apply:

- ☐ None
- ☐ Private health insurance through your employer or your partner's employer
- ☐ Private health insurance purchased by yourself or your partner, such as through a healthcare market exchange
- ☐ Medicaid
- ☐ Medicare
- ☐ Tricare or other military health insurance, including VA healthcare
- ☐ Any other insurance that covers part of your medical bills, please specify:

I5. Have concerns about losing your health insurance kept you in a job since your diagnosis of endometrial cancer?

- ■ Yes
- ■ No
- ■ Have not had a job since diagnosis

I6. On a scale of 1 to 10 with 1 being "No Confidence" and 10 being "High Confidence", how confident are you that you could find the money to pay for a financial emergency that costs about $1,000?



I7. On a scale of 1 to 10 with 1 being “Always” and 10 being “Never”, how frequently do you find yourself “just getting by” financially or living paycheck to paycheck?

1	2	3	4	5	6	7	8	9	10
■	■	■	■	■	■	■	■	■	■
Always									Never

I8. On a scale of 1 to 10 with 1 being “Always Hard” and 10 being “Never Hard”, how hard is it for you to pay for the very basics, like food, housing, medical care, and heating?

1	2	3	4	5	6	7	8	9	10
■	■	■	■	■	■	■	■	■	■
Always Hard									Never Hard

The next questions ask how you feel about your financial situation as it relates to your endometrial cancer care.

Please answer the following statements with your response as it applies to the past 7 days:

		Not at all	A little bit	Some-what	Quite a bit	Very much
I9.	I know that I have enough money in savings, retirement, or assets to cover the cost of my treatment.	■	■	■	■	■
I10.	My out-of-pocket medical expenses are more than I thought they would be.	■	■	■	■	■
I11.	I worry about the financial problems I will have in the future as a result of my illness or treatment.	■	■	■	■	■
I12.	I feel I have no choice about the amount of money I spend on care.	■	■	■	■	■
I13.	I am frustrated that I cannot work or contribute as much as I usually do.	■	■	■	■	■
I14.	I am satisfied with my current financial situation.	■	■	■	■	■
I15.	I am able to meet my monthly expenses.	■	■	■	■	■
I16.	I feel financially stressed.	■	■	■	■	■
I17.	I am concerned about keeping my job and income, including my work at home.	■	■	■	■	■
I18.	My cancer or treatment has reduced my satisfaction with my current financial situation.	■	■	■	■	■
I19.	I feel in control of my financial situation.	■	■	■	■	■
I20.	I have been distressed by not knowing what my cancer care would cost.	■	■	■	■	■
I21.	I am worried about the financial stress on my family as a result of my cancer.	■	■	■	■	■

I22. Since our last contact, or within the last 12 months, was there a time you wanted to see a doctor, but could not because of transportation issues?

- ■ Yes
- ■ No

I23. Since our last contact, or within the last 12 months, have you ever been contacted by a collection agency as a result of your cancer care?

- ■ Yes
- ■ No

I24. Since our last contact, or within the last 12 months which of the following have you done to manage your cancer care cost?

Skipped a vacation or other activity due to cost?	■ Yes	■ No
Borrowed money from friends, family, a bank, or another source?	■ Yes	■ No
Taken money from a savings or retirement account?	■ Yes	■ No
Filed for bankruptcy?	■ Yes	■ No
Filed for disability?	■ Yes	■ No
Avoided treatment for another medical problem other than your cancer?	■ Yes	■ No
Skipped paying non-medical bills, like rent, credit cards, or other necessities?	■ Yes	■ No
Applied for financial assistance?	■ Yes	■ No
Received financial assistance?	■ Yes	■ No

SECTION J: PERSPECTIVES ON DISCRIMINATION

We are interested in the experiences of endometrial cancer survivors across different parts of their lives. Since our last contact, or within the last 12 months, in your day-to-day life, how often have any of the following things happened to you?

Please answer the following statements with your level of agreement:

		Almost every day	At least once a week	A few times a month	A few times a year	Less than once a year	Never
J1.	You are treated with less courtesy than other people are.	■	■	■	■	■	■
J2.	You are treated with less respect than other people are.	■	■	■	■	■	■
J3.	You receive poorer service than other people at restaurants or stores.	■	■	■	■	■	■
J4.	People act as if they think you are not smart.	■	■	■	■	■	■
J5.	People act as if they are afraid of you.	■	■	■	■	■	■
J6.	People act as if they think you are dishonest.	■	■	■	■	■	■
J7.	People act as if they're better than you are.	■	■	■	■	■	■
J8.	You are called names or insulted.	■	■	■	■	■	■
J9.	You are threatened or harassed.	■	■	■	■	■	■

J10. If you answered "A few times a year" or more frequently to any of the 9 statements above, what do you think is the main reason for these experiences? **[Please select only one]**

- ■ Not applicable
- ■ Your ancestry or national origins
- ■ Your gender
- ■ Your race
- ■ Your age
- ■ Your religion
- ■ Your height
- ■ Your weight
- ■ Some other aspect of your physical appearance
- ■ Your sexual orientation
- ■ Your education or income level
- ■ Other

J11. If there are any other reasons you think you have had these experiences, please mark them below. [Select all that apply]

- ☐ Not applicable
- ☐ Your ancestry or national origins
- ☐ Your gender
- ☐ Your race
- ☐ Your age
- ☐ Your religion
- ☐ Your height
- ☐ Your weight
- ☐ Some other aspect of your physical appearance
- ☐ Your sexual orientation
- ☐ Your education or income level
- ☐ Other

SECTION K: FUTURE CONTACT / CLOSING COMMENTS

Thank you again for your participation in this follow-up survey. We greatly appreciate your willingness to provide this updated information.

K1. We plan to contact you again in about a year with a newsletter and to check in with how you are doing. In case we can't reach you, is there a name and phone number you can give us for a friend or relative who may be able to help us contact you?

- ■ Yes
- ■ No ➔ **SKIP TO K2**

1st Contact:

Name: _____ Relationship: _____

Phone 1: _____

Phone 2: _____

Email: _____

2nd Contact:

Name: _____ Relationship: _____

Phone 1: _____

Phone 2: _____

Email: _____

K2. Before we complete this survey, do you have any questions or comments to share?

_____

_____

_____

_____

_____

_____

Thank You for completing this survey.
You should be receiving a mailing from us within 4 weeks, including payment of $40 to thank you for taking the time to complete this survey.

Question D1-D25a-b Charleston Comorbidity Index (CCI) Habbous S, Chu KP, Harland LTG, et al. Validation of a one-page patient-reported Charlson comorbidity index questionnaire for upper aerodigestive tract cancer patients. Oral Oncology. 2013;49(5):407-412. doi:10.1016/j.oraloncology.2012.11.010

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Question G1-G8 Patient Reported Outcomes Measurement Information System (PROMIS®) SHORT FORM- COGNITIVE FUNCTION 8A Henneghan, A. M., Van Dyk, K., Zhou, X., Moore, R. C., Root, J. C., Ahles, T. A., Nakamura, Z. M., Mandeblatt, J., & Ganz, P. A. (2023). Validating the PROMIS cognitive function short form in cancer survivors. Breast cancer research and treatment, 201(1), 139–145. https://doi.org/10.1007/s10549-023-06968-2

***Question G1-8 also used to complete NCCN Guideline Version 2.2019 Survivorship Assessment** Sanft T, Denlinger CS, Armenian S, et al. NCCN Guidelines Insights: Survivorship, Version 2.2019. J Natl Compr Canc Netw. 2019;17(7):784-794. doi:10.6004/jnccn.2019.0034

Question G9-G16 Patient Reported Outcomes Measurement Information System (PROMIS®) Depression, Anxiety, and Anger v1.0 Pilkonis PA, Choi SW, Reise SP, et al. Item banks for measuring emotional distress from the patient-reported outcomes measurement information system (Promis®): depression, anxiety, and anger. Assessment. 2011;18(3):263-283. doi:10.1177/1073191111411667

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Question H1-H10 Patient Reported Outcomes Measurement Information System (PROMIS®) v1.0 Global Health Hays RD, Bjorner JB, Revicki DA, Spritzer KL, Cella D. Development of physical and mental health summary scores from the patient-reported outcomes measurement information system (PROMIS) global items. Qual Life Res. 2009;18(7):873-880. doi:10.1007/s11136-009-9496-9

Question H15-H23 Older Americans Resources and Services Multidimensional Functional Assessment Questionnaire (OARS) Maddox G. Duke university center for the study of aging and human development: past, present, and future. Gerontology & Geriatrics Education. 1993;14(1):5-9. doi:10.1300/J021v14n01_02

Question I9-21 COST: A FACIT Measure of Financial Toxicity (FACIT-COST) V.2 De Souza JA, Yap BJ, Wroblewski K, et al. Measuring financial toxicity as a clinically relevant patient-reported outcome: The validation of the Comprehensive Score for financial Toxicity (Cost): Measuring Financial Toxicity. Cancer. 2017;123(3):476-484. doi:10.1002/cncr.30369

Question J1-J10 Everyday Discrimination Scale Williams DR, Yan Yu, Jackson JS, Anderson NB. Racial differences in physical and mental health: socio-economic status, stress and discrimination. J Health Psychol. 1997;2(3):335-351. doi:10.1177/135910539700200305

Questions C4a, D2, D4-5, D7-12, D16, D19-22, D27, D24a, E4-5, E7b-8, G1-G16, H1-H23 Used for calculating the **CARE Frailty Index (CARE-FI)** Giri S, Al-Obaidi M, Harmon C, et al. Patient-reported geriatric assessment-based frailty index among older adults with gastrointestinal malignancies. J Am Geriatr Soc. 2023;71(1):136-144.