LEO (Lymphoma Epidemiology & Outcomes) Baseline Enrollment Questionnaire

To be completed by Participant at time of Enrollment

Mayo Clinic
Return to:
Lymphoma/ CLL Study Coordinators
Charlton 6
Internal Ext: 87093
1-800-610-7093

Instructions: Please answer the following questions to the best of your ability. This questionnaire is for research purposes only, and will not become part of your medical record.

Date Form Completed	____/____/_____ (mm/dd/yyyy)	
Email Address		
Date of Birth	____/____/_____ (mm/dd/yyyy)	DEMOGRAPHIC
Gender	☐ Male ☐ Female	
Are you of Hispanic or Latino origin?	☐ No ☐ Yes ☐ I don't know	
Which best describes your racial background?	☐ American Indian/Alaska Native ☐ Asian ☐ Black or African American ☐ White ☐ Native Hawaiian or other Pacific Islander ☐ None of the above ☐ I don't know	
What is your current weight?*	__ __ __ pounds	DEMOGRAPHICS
What is your current height?*	__ feet __ inches	
What was your weight one month ago?*	__ __ __ pounds	
What was your weight 6 months ago?*	__ __ __ pounds	
During the past 2 weeks, did your weight:*	☐ decrease ☐ no change ☐ Increase	
At the time of your lymphoma/CLL diagnosis, have you ever had any of the following diseases or conditions diagnosed by a health care professional?		
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	PaRC
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 ☐ 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
Shingles	☐ No ☐ Yes
Sinusitis	☐ 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 legs or abdomen ☐ Pulmonary Embolism (PE) Clot in lungs	
Are you currently on Blood Thinning Medication? (NOT aspirin)	☐ No (skip to next question) ☐ Yes (Please provide type below) ☐ Coumadin (Warfarin) ☐ Heparin ☐ enoxaparin (Lovenox) ☐ dabigatran (Pradaxa) ☐ apixaban (Eliquis) ☐ rivaroxaban (Xarelto) ☐ Other ☐ Don't know	
Have you had an organ transplant?	☐ No ☐ Yes Specify _____	
Autoimmune or other immune disorder?	☐ No (skip to next section) ☐ Yes (Please provide type below) ☐ Rheumatoid Arthritis (RA) ☐ Systemic Lupus Erythematosus (SLE) ☐ Wegner's Granulomatosis (WG) ☐ Temporal Arteritis ☐ Systemic Vasculitis ☐ Sjogren's Syndrome ☐ Other: Specify _____	
Other Cancer Diagnosis **(DO NOT REPORT ON CURRENT LYMPHOMA DIAGNOSIS)**		
Do you currently, or have you had another type of cancer? **(NOT CURRENT LYMPHOMA DIAGNOSIS)**	☐ No (skip to next section) ☐ Yes (list most recent details below)	OCD
Age at first diagnosis of other cancer	___ ___ ___ Years old	
Type of Cancer	Cancer type:	
Are you being treated for other cancer **(NOT LYMPHOMA)**	☐ No ☐ Yes (list treatment below) Check all that apply ☐ Systemic Therapy (Chemo, Hormone, Targeted Therapy) ☐ Surgical Resection ☐ Radiation ☐ Other, specify:	
If more than one type of cancer, complete this section	Age at first diagnosis: ____Type of Cancer: _____ Age at first diagnosis: ____Type of Cancer: _____ Age at first diagnosis: ____Type of Cancer: _____	

QOL Remainder of Questionnaire

**Please respond to each item by marking one box per row					
	Excellent	Very Good	Good	Fair	Poor
In general, would you say your health is:	5	4	3	2	1
In general, would you say your quality of life is:	5	4	3	2	1
In general, how would you rate your physical health?	5	4	3	2	1
In general, how would you rate your mental health, including your mood and ability to think?	5	4	3	2	1
In general, how would you rate your satisfaction with your social activities and relationships	5	4	3	2	1
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)	5	4	3	2	1
	Completely	Mostly	Moderately	A little	Not at all
To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	5	4	3	2	1
In the last 7 days…	Never	Rarely	Sometimes	Often	Always
How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	1	2	3	4	5
	None	Mild	Moderate	Severe	Very Severe
How would you rate your fatigue on average?	1	2	3	4	5

	No Pain										Worst Imaginable Pain
How would you rate your pain on average?	0	1	2	3	4	5	6	7	8	9	10

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 (episodes 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

∆In general, compared to other people your age, would you say your health is:	☐Poor ☐ Fair ☐ Good ☐ Very Good ☐ Excellent

∆How much Difficulty, on average do you have with the following physical activities? (select one per question)					
	No Difficulty	**A little Difficulty**	**Some Difficulty**	**A Lot of Difficulty**	**Unable to do**
Stooping, crouching or kneeling?	☐	☐	☐	☐	☐
Lifting or carrying objects as heavy as 10 pounds?	☐	☐	☐	☐	☐
Reaching or extending arms above shoulder level?	☐	☐	☐	☐	☐
Writing, or handling and grasping small objects?	☐	☐	☐	☐	☐
Walking a quarter of a mile?	☐	☐	☐	☐	☐
Heavy housework such as scrubbing floors and washing windows?	☐	☐	☐	☐	☐

∆Because of your health or a physical condition, do you have any difficulty:	
Shopping for personal items (like toilet items or medicine)?	☐ No (move to next question) ☐ Yes – Do you get help with shopping? ☐ Yes ☐ No ☐ Don't Do – Is that because of your health? ☐ Yes ☐ No
Managing money (like keeping track of expenses or paying bills)?	☐ No (move to next question) ☐ Yes – Do you get help with managing money? ☐ Yes ☐ No ☐ Don't Do – is that because of your health? ☐ Yes ☐ No
Walking across the room? USE OF CANE or WALKER IS OK	☐ No (move to next question) ☐ Yes – Do you get help with walking? ☐ Yes ☐ No ☐ Don't Do – is that because of your health? ☐ Yes ☐ No
Doing light housework (like washing dishes, straightening up, or light cleaning)?	☐ No (move to next question) ☐ Yes – Do you get help with light housework? ☐ Yes ☐ No ☐ Don't Do – Is that because of your health? ☐ Yes ☐ No
Bathing or showering?	☐ No (move to next section ☐ Yes – Do you get help with bathing or showering? ☐ Yes ☐ No ☐ Don't Do – is that because of your health? ☐ Yes ☐ No

***FOOD INTAKE:** As compared to my normal intake, I would rate my food intake during the past month as:	☐ unchanged ☐ more than usual ☐ less than usual **(if checked, select answer below)** I am now taking: ☐ *normal food* but less than normal amount ☐ little solid food ☐ only liquids ☐ only nutritional supplements ☐ very little of anything ☐ only tube feedings or only nutrition by vein	
***SYMPTOMS:** I have had the following problems that have kept me from eating enough during the past two weeks (check all that apply)	☐ no problems eating ☐ nausea ☐ constipation ☐ mouth sores ☐ no appetite, just did not feel like eating ☐ things taste funny or have no taste ☐ problems swallowing	☐ pain: where? _____ ☐ vomiting ☐ diarrhea ☐ dry mouth ☐ smells bother me ☐ feel full quickly ☐ fatigue ☐ other: _____ (examples: depression, money, dental problems)
***ACTIVITIES and FUNCTION:** 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 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	

*Scored Patient-Generated Subjective Global Assessment (PG-SCA) ©FD Ottery 2005, 2006, 2015 v3.22.15
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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