MAYO CLINIC

200 First Street SW
Rochester, Minnesota 55905
507-284-2511

May 31, 2017

«FIRST» «LAST»
«ADDRESS_LINE1» «ADDRESS_LINE2»
«City», «State» «ZIPCODE»

Dear «FIRST» «LAST»:

Thank you for taking the time to discuss your health with us as part of our ongoing research study.

At your convenience, please complete the following document(s):
(documents included in letter are indicated below)

☒ **LEO 6 month Follow Up Questionnaire**

When you complete the Questionnaire(s), please send them back in the enclosed postage paid envelope(s).

All information will be kept strictly confidential and will not become part of your medical record. If at any time you have any questions concerning this research study, please do not hesitate to contact us at 1-800-610-7093.

Thank you. Your participation is greatly appreciated.

Sincerely,

The Lymphoma Research Team

LEO Lymphoma Epidemiology of Outcomes

****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

«LEO_ID»
«LOCAL_ID»
TIMEPOINT: «timepoint»

****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

«LEO_ID»
«LOCAL_ID»
TIMEPOINT: «timepoint»

****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:

At any time from when you were first diagnosed with cancer until now, were you working for pay at a job or business?	☐ No ☐ Yes
IF YES to above question: At any time since your diagnosis, did you take extended paid time off from work, unpaid time off, or make a change in your hours, duties, or employment status?	☐ No ☐ Yes ☐ Not applicable
Because of your cancer, its treatment, or the lasting effects of that treatment, did any of your caregivers ever take extended paid time off from work, unpaid time off, or make a change in their hours, duties or employment status?	☐ No ☐ Yes
Because of your cancer, its treatment, or the lasting effects of that treatment, did <u>you</u> or any of your caregivers take an extra job or work additional hours?	☐ No ☐ Yes
Have you or has anyone in your family had to borrow money or go into debt because of your cancer, its treatment or the lasting effects of that treatment?	☐ No ☐ Yes
Did you or your family ever file for bankruptcy because of your cancer, its treatment, or the lasting effects of that treatment?	☐ No ☐ Yes
Please think about medical care visits for cancer, its treatment, or the lasting effects of that treatment. Have you ever been unable to cover your share of those visits?	☐ No ☐ Yes

…Please continue next page

«LEO_ID»
«LOCAL_ID»
TIMEPOINT: «timepoint»

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

At any time since you were first diagnosed with cancer, did you get all of the medical care, tests, or treatments that you or your doctor believed were necessary? ☐ No - if no, please answer reason to right (select all that apply) ☐ Yes, move to next question below	☐couldn't afford care ☐insurance company wouldn't approve or pay for care ☐had problems getting to the doctor's office ☐doctor did not accept your insurance ☐couldn't get time off work ☐did not know where to go to get care ☐couldn't get child/adult care ☐did not have time – care/test/treatment took too long ☐other reason

Have you or your family had to make any other kinds of financial sacrifices because of your cancer, its treatment, or the lasting effects of that treatment?	☐ No ☐ Yes
Have you ever worried about having to pay large medical bills related to your cancer?	☐ No ☐ Yes

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 cancer 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

«LEO_ID»
«LOCAL_ID»
TIMEPOINT: «timepoint»