MAYO CLINIC

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

May 31, 2017

«First_Name» «Last_Name»
«Current_address_line1» «Current_address_line2»
«City», «State» «Zip_code»

Dear «First_Name» «Last_Name»:

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 Follow Up Questionnaire (mo. 18, 30, 36)**

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)****

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****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

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

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 ☐ N/A
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

«LEO_ID»
«LOCAL_ID»
TIMEPOINT: «timepoint»

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

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 ☐ 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: _____.