MER Baseline Enrollment Questionnaire

To be completed by Participant at time of Enrollment

Mayo Clinic
Return to:
Lymphoma/CLL Study Coordinators
Charlton 6
Internal Ext: 87039
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.

Baseline Enrollment

This section to be completed by study staff:
MERID: _____
MC/IA ID: _____
Time point questionnaire completed[1]: Baseline

Date Form Completed		
Date of Birth		DEMOGRAPHICS
Gender	☐ Male ☐ Female	
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	
Are you of Hispanic or Latino origin?	☐ No ☐ Yes ☐ I don't know	
At the time of your lymphoma/CLL diagnosis, did you have any of the following diseases or conditions?		
Heart Disease	☐ No (skip to next question) ☐ Yes (select specific below) ☐ 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
Sugar Diabetes	☐ No (skip to next question) ☐ Yes (select type below) ☐ Type 1 ☐ Type 2 ☐ Type Unknown	
Hepatitis	☐ No (skip to next question) ☐ Yes (select type below) ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C	
Shingles	☐ No ☐ Yes	
Hip Fracture (broken hip)	☐ No ☐ Yes	
Other Broken Bones	☐ No ☐ Yes	
Osteoporosis (Brittle Bones)	☐ No ☐ Yes	
Premature Menopause	☐ No ☐ Yes ☐ N/A	
Infertility	☐ No ☐ Yes	
Blood Clot	☐ No ☐ Yes (Please provide type below) ☐ 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 ☐ Yes (Please provide type below) ☐ Coumadin (Warfarin) ☐ Heparin	
Have you had an organ transplant?	☐ No ☐ Yes	
Autoimmune or other immune disorder?	☐ No ☐ 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 _____	
Do you currently, or have you had another type of cancer?	☐ No (skip to next section) ☐ Yes (list most recent details below)	OCD
Age at first diagnosis of other cancer		
Type of Cancer		
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: _____	

Select one of the following that best describes your ability to carry on daily activities		
	0	Fully Active, able to carry on all activity without restriction
	1	Restricted in physically strenuous activity but able to walk and able to carry out work of a light or sedentary nature, e.g., light house work or office work
	2	Able to walk and capable of all self-care, but unable to carry out any work activities. Up to and about more than 50% of waking hours
	3	Capable of only limited self-care, confined to bed or chair more than 50% of waking hours
	4	Completely disabled. Cannot carry on any self-care. Totally confined to bed or chair
		NOT KNOWN
		I decline to answer

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	

Your Overall Spiritual Well-Being										
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

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 (especially 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

Thank you for taking the time to complete this form.

If at any time you have questions, please contact us at: MAYO: 1-800-610-7093 IOWA: 1-319-353-6125