Questions for your Survivorship Appointment

All patients are asked to complete this questionnaire as part of their standard of care. Please take a few minutes to answer the following questions to help us better address your needs.

equal hope

Over the **last 14 days,** how often have you been bothered by the following problems?

Please mark one box per row	**Not at all**	**Several Days**	**More than half the days**	**Nearly every day**
Feeling nervous, anxious or on edge	❑	❑	❑	❑
Not being able to stop or control worrying	❑	❑	❑	❑
Little interest or pleasure in doing things	❑	❑	❑	❑
Feeling down, depressed, or hopeless	❑	❑	❑	❑
Fear of developing another cancer or a recurrence	❑	❑	❑	❑

Please indicate if you developed any of the below concerns as a result of your cancer treatment by checking Yes or No for each.

YES	NO	**Financial Concerns**
❑	❑	Paying for food and/or housing
❑	❑	Paying for my medication or medical care
❑	❑	Insurance coverage or no health insurance

YES	NO	**Social Concerns**
❑	❑	Concerns about my children
❑	❑	Concerns about my partner
❑	❑	Issues with work or school

YES	NO	**Spiritual / Faith / Religious Concerns**
❑	❑	

YES	NO	**Nutrition Concerns**
❑	❑	Concerns about body weight
❑	❑	Concerns about diet (food) and cancer risk/incidence
❑	❑	Concerns about alternative/herbal supplements

YES	NO	**Treatment or Care Concerns**
❑	❑	Lack understanding about my cancer diagnosis or stage
❑	❑	Have questions about potential long term complications from my treatment
❑	❑	Developed other illnesses as a result of my cancer treatment
❑	❑	Issues with transportation to/from appointments
❑	❑	Need help coordinating my care
❑	❑	Need cancer screening

Other problems or concerns:

_____

_____

YES	NO	**Physical Concerns**
❑	❑	Ability to have children
❑	❑	Appearance
❑	❑	Breathing
❑	❑	Constipation or Diarrhea
❑	❑	Hot flashes and/or vaginal dryness
❑	❑	Nausea or Vomiting
❑	❑	Difficulty with chewing or swallowing due to cancer therapy
❑	❑	Pain
❑	❑	Sexual intimacy or function
❑	❑	Dry skin
❑	❑	Sleep
❑	❑	Decreased range of motion or loss of strength
❑	❑	Lower energy level
❑	❑	Swollen arms/legs
❑	❑	Tingling in my hands/feet
❑	❑	Trouble remembering, concentrating

Please indicate which factors may be relevant to your lifestyle by checking Yes or No for each.

YES	NO	**Life Style Factors**
❑	❑	I use tanning beds
❑	❑	I am often outside, in the sun
❑	❑	I use tobacco
❑	❑	I use prescription pain medication for reasons other than pain control
❑	❑	I exercise regularly
❑	❑	I drink alcohol
❑	❑	I use recreational drugs

*This tool is adapted from: (1) The National Comprehensive Cancer Network, NCCN Guidelines®for Distress Management, Problem List, Version 3.2015; (2) the PHQ-4 developed by Kroenke K, Spitzer RL, Williams JB, Löwe B.; (3) American Society of Clinical Oncology, *Providing High Quality Survivorship Care in Practice: An ASCO Guide*, (2014)