# OncoLife Survey

Use the attached list of cancer treatments to help you complete the treatment questions on this survey. The list includes treatments that are most often used to treat your type of cancer.

**1. Name:**

**2. Gender:**
- ☐ Male
- ☐ Female

**3. Race:**
- ☐ White/Non-Hispanic
- ☐ African American or Black
- ☐ Asian
- ☐ Hispanic/Latino/Latina
- ☐ Native American/Aleutian/Eskimo
- ☐ Pacific Islander
- ☐ Mixed Race
- ☐ Other

**4. Age at Diagnosis:** _____

**5. Current Age:** _____

**6. Highest Education Level:**
- ☐ Grade School
- ☐ High School
- ☐ Some College
- ☐ College Degree (BA, BS)
- ☐ Graduate Degree (MD, PhD, JD)
- ☐ Don't Know

**7. Have you (or the patient) ever been offered survivorship health information before?**
- ☐ Yes
- ☐ No
- ☐ I Don't Know

**8. Have you (or the patient) ever received a treatment summary?** A treatment summary is simply a document that details the cancer treatments you received. This would include any surgery, chemotherapy (or other medical therapy) and radiation therapy.
- ☐ Yes
- ☐ No

□ I Don't Know

**9. Who is currently managing your health care needs?**

□ Oncologist
□ Primary Care Physician or Internist
□ Combination of Oncologist and Primary Care Physician/Internist
□ Other

**9. What is your geographical location?**

□ USA; State:_____
□ Canada; Province: _____
□ Other Country: _____

**10. For Female Participants Only:**

□ Menopause occurred before cancer therapy
□ Postmenopausal (defined as 12 consecutive months without a period)
□ Menopause occurred after cancer therapy, but not due to therapy
□ Premenopausal
□ Perimenopausal (this is the time of transition to menopause)
□ Not sure (recently completed therapy, unsure if periods will return)

**11. Cancer Types: Please check all that apply.**

□ Acute Lymphocytic Leukemia
□ Acute Myeloid Leukemia
□ Anal Cancer
□ Appendiceal Cancer
□ Bladder Cancer
□ Brain Cancer
□ Breast Cancer
□ Cervical Cancer
□ Chronic Lymphocytic Leukemia
□ Chronic Myelogenous Leukemia
□ Colon Cancer
□ Endometrial Cancer
□ Esophageal Cancer
□ Fallopian Tube Cancer
□ Gall Bladder / Cholangiocarcinoma
□ Head&Neck:Tongue/Lip/Oropharynx/Nasopharynx
□ Hodgkin's Disease
□ Kidney Cancer
□ Liver Cancer
□ Lung Cancer
□ Lymphoma
□ Melanoma
□ Mesothelioma
□ Multiple Myeloma
□ Myelodisplastic Syndrome
□ Non-Melanoma Skin Cancers
□ None
□ Other Cancer
□ Ovarian Cancer/Primary Peritoneal Cancer
□ Pancreatic Cancer
□ Penile Cancer

- □ Prostate Cancer
- □ Rectal Cancer
- □ Sarcoma
- □ Stomach Cancer
- □ Testicular Cancer
- □ Thymoma or Thymic Carcinoma
- □ Thyroid Cancer
- □ Uterine Cancer
- □ Vaginal or Vulvar Cancers

**12. Do any of the following describe your situation?**

□ Yes, I am living with metastatic cancer.

□ Yes, I have a recurrence of a previous cancer or 2nd diagnosis of cancer.

□ No, neither of these describes my situation.

***Treatment Questions***

**13. Did you undergo surgery for this cancer?**

□ Yes

□ No

**13a. If you underwent surgery, what procedures were done? (See attached list of treatments to help you if you are unsure)**

_____

_____

_____

_____

**14. Did you receive medication, IV (administered into your vein) or oral (by mouth), for treatment of this cancer (including chemotherapy and biologic therapy)?**

□ Yes

□ No

**14a. IF YES: What medications did you receive?** (see attached reference sheet)

_____

_____

_____

**15. Did you receive hormone therapy medication, IV (administered into your vein) or oral (by mouth), for treatment of this cancer? (Most often used for breast, gynecologic, and prostate cancers)**

□ Yes

□ No

**15a. If YES, what hormone therapies did you receive?** (see attached reference sheet)

---

**16. Did you receive intrathecal chemotherapy (administered into your spinal fluid)?**

□ Yes
□ No

**16a. If you received intrathecal chemotherapy, what medications were received?** (check all that apply)

☐ Cytarabine (Cytosar-U®, Ara-C)
☐ Fluorouracil (Adrucil®, 5-fluorouracil, 5-FU)
☐ Methotrexate (Rheumatrex®, Trexall™, MTX)

**17. Did you receive therapy administered into your bladder (called intravesicular)?** (Used to treat some bladder cancers)

**17a. If you received therapy into the bladder, which medications did you receive?**

_____

**18. Did you receive radiation therapy?**

□ Yes
□ No

**18a. If you received radiation, what type of radiation did you receive?**

☐ X-ray based Radiation (most common) (choose one of the following):
  ☐ Conformal Radiotherapy (most common type used)
  ☐ IMRT
  ☐ Don't Know
☐ Brachytherapy (radiation implant)
☐ Stereotactic radiosurgery (also called Cyber knife or Gamma knife)
☐ Proton-based Radiation (Proton therapy)
☐ Cobalt-based radiation

**18b. What cancer/area was the radiation therapy treating? (ex: for breast cancer, for head & neck cancer)**

---

**19. Did you have radiation treatment for metastatic cancer?**

□ Yes
□ No

**19a. If YES, what area was treated? (ex: bone, brain, lung)**

---

**20. Did you undergo a bone marrow or stem cell transplant?**

□ No
□ Yes – choose one of the following:
☐ Allogeneic (donor cells)
☐ Autologous (my own cells)

**20a. Did you have total body irradiation? (Used for bone marrow transplant)**

□ Yes
□ No

**21. Have you been told you have a genetic abnormality or syndrome?**

□ Yes
□ No

**22. Tobacco dependence, in all of its forms, can sometimes be difficult to overcome, and is often a confusing issue for survivors and their families.**

a) Would you like information about smoking or tobacco cessation resources for **yourself**?
□ Yes
□ No
b) Would you like information to help you understand tobacco dependence better or to support **someone else** in cessation?
□ Yes
□ No