Survivorship Questionnaire

These questions highlight some concerns people can experience as a result of cancer and its treatment. For each, please circle the response that best describes how you have been feeling in the past 2 weeks.

	Never	Rarely	Sometimes	Very Often	Always
I feel nervous or worried.	1	2	3	4	5
I feel sad or depressed.	1	2	3	4	5
I am not interested in things I use to enjoy.	1	2	3	4	5
I have difficulty multi-tasking or paying attention.	1	2	3	4	5
I have difficulty remembering things.	1	2	3	4	5
My thinking seems slow.	1	2	3	4	5
I have trouble breathing.	1	2	3	4	5
I have shortness of breath or chest pain with physical activity	1	2	3	4	5
I have shortness of breath when lying flat, waking up at night needing to get air, or persistent leg swelling.	1	2	3	4	5
I feel tired despite having a good night's sleep.	1	2	3	4	5
My fatigue interferes with my usual activities.	1	2	3	4	5
I have pain.	1	2	3	4	5
I am not satisfied with my sexual function.	1	2	3	4	5
I have concerns about my sexual health.	1	2	3	4	5
I have problems falling or staying asleep.	1	2	3	4	5
I sleep too much.	1	2	3	4	5
I have numbness or tingling in my hands or feet.	1	2	3	4	5
I have aches or pain in my arms, legs, or joints.	1	2	3	4	5
I have hot flashes.	1	2	3	4	5
I worry about cancer coming back	1	2	3	4	5
I have financial trouble due to my healthcare costs	1	2	3	4	5
I am sitting or lying down most of the day	1	2	3	4	5
I would like to improve my fitness or nutrition	1	2	3	4	5

What concerns are your top priority for today's visit?

Issue 1._____

Issue 2._____

Issue 3. _____

Demographics (Please complete):

Age: Gender:

Race/Ethnicity:

Type of Cancer(s):

Year of initial diagnosis: