Participant ID 0 0 0 0

Three Year Follow-up Survey

CEASAR STUDY

Thank you for your continued participation in the CEASAR study. This follow-up questionnaire is about your quality of life and other experiences related to your prostate cancer and its treatment. To help us get the most accurate information, it is important that you answer all questions honestly and completely about your own experience. You may skip any questions that you are uncomfortable answering. Your responses will help us in our efforts to learn more about how to best treat prostate cancer, and what men experience after treatment.

Information contained within this survey will remain strictly confidential.

Thank you very much for your assistance in answering these questions.

Participant ID 0 0 0 0

General Instructions

PLEASE READ THESE INSTRUCTIONS CAREFULLY

- Answer each question as best you can. If you choose to skip a question, please write 'skip' next to it.

- Please fill in the oval next to your answer completely using blue or black ink.

  Example: Fill in ovals completely, like this: ⬬
  Not like this: ⊗ Or this: ◉

- Please follow any instructions that direct you to the next question.

  Example: ⬬ No *(If No, go to the 'If No' section on the next page)*

- If you mark an answer with a line after it, please write the specific information on the line.

  Example:

  ⬬ Other, please specify: *my friend who is a doctor*

- Mark only one response for each question, unless other instructions are given.

- If you mark the wrong oval by mistake, put an X through it and fill in the correct answer, like this: ⬬

- As much as possible, please try to answer all of the questions in one sitting.

Participant ID ___ 0 0 0 0 ___

1. Today's date: ____ / ____ / 2 0 ____
Month Day Year

A. Recent PSA Testing

2. Did you have a PSA drawn **within the last 12 months?**

- ⚪ Yes
- ⚪ No *(If No, skip the next question and go to Question 4)*

3. If you had a PSA drawn **in the last 12 months**, what is your most recent result? ____ . ____

- ⚪ I had a PSA drawn in the last 12 months, but I do not know what the result was.

B. Prostate Cancer Recurrence

4. Since you were initially diagnosed, did your doctor ever tell you that your prostate cancer came back (recurred) or progressed (got worse)?

- ⚪ Yes
- ⚪ No

5. As far as you know, is your prostate cancer currently cured or in complete remission?

- ⚪ Yes
- ⚪ No

Please go to the next page.

C. Prostate Cancer Treatments

6. Please think of ALL the treatments you have received for your prostate cancer. Answer the questions below using the following instructions:

Column A. Fill in the bubble for "Yes" for all the treatments you have had.
Column B. For each treatment you have had, also fill in the date the treatment started. If you can't remember the exact date that you received or started therapy, please at least enter the year.
Column C. If you are still on or receiving a particular treatment, please also fill in the bubble all the way to the right.

I. Treatment to the prostate	A. Had treatment? Yes	B. Date Started: Month	Year	C. Still taking/ receiving? Yes
a. Active surveillance/watchful waiting (no treatment)	○	___ /	2 0 ___	○
b. Robotic/laparoscopic surgical removal of the prostate	○	___ /	2 0 ___	
c. Open surgical removal of the prostate (using a long incision)	○	___ /	2 0 ___	
d. Insertion of radiation seeds/rods (brachytherapy)	○	___ /	2 0 ___	
e. External beam radiation, where beams are aimed in from outside your body (some other names for this treatment include IMRT (Intensity-Modulated Radiation Therapy), IGRT (Image-Guided Radiation Therapy), arc therapy, proton beam, cyberknife, or 3D-conformal beam therapy)	○	___ /	2 0 ___	○
f. Other types of radiation therapy, or unsure of what type	○	___ /	2 0 ___	○
g. Cryotherapy (freezing of the prostate)	○	___ /	2 0 ___	
h. Other treatments to the prostate (HIFU (High Intensity Focused Ultrasound), RFA (Radio Frequency Ablation), laser, focal therapy)	○	___ /	2 0 ___	

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II. Other treatments

Column A. Fill in the bubble for "Yes" for all the treatments you have had.
Column B. For each treatment you have had, also fill in the date the treatment started. If you can't remember the exact date that you received or started therapy, please at least enter the year.
Column C. If you are still on or receiving a particular treatment, please also fill in the bubble all the way to the right.

	A. Had treatment?	B. Date Started:		C. Still taking/ receiving?
	Yes	Month	Year	Yes
i. Surgical removal of the testicles (orchiectomy)	○	___ /	2 0 __ __	
j. Hormone shots (Lupron, Zoladex, Firmagon, Eligard, Vantas, etc.)	○	___ /	2 0 __ __	○
k. Casodex (bicalutamide) or Eulexin (flutamide) pills	○	___ /	2 0 __ __	○
l. Zytiga (abiraterone) or Xtandi (enzalutamide) pills	○	___ /	2 0 __ __	○
m. Provenge/immunotherapy (Sipuleucel T)	○	___ /	2 0 __ __	○
n. Chemotherapy (docetaxel, cabazitaxel, other chemotherapy)	○	___ /	2 0 __ __	○
o. Radiation to the bones (either with beams from the outside or Xofigo (Radium-223) therapy)	○	___ /	2 0 __ __	○
p. Other therapy (Please specify): ______________________	○	___ /	2 0 __ __	○

Please go to the next page.

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D. Active Surveillance/Watchful Waiting

If you initially elected active surveillance/watchful waiting for your prostate cancer, please answer the following questions. *If you were never on active surveillance/watchful waiting, please skip these questions and go to Question 9.*

7. Did you eventually get other treatment (i.e., surgery, radiation, hormones)?

- ○ Yes, and the approximate start date of the treatment was ___ / 20___
- ○ No *(If No, please go to Question 9)*

8. If you started on active surveillance/watchful waiting and then got other treatment, why did you get treated? *(Choose all that apply)*

- ○ My doctor said my prostate cancer had gotten worse
- ○ My prostate cancer was a higher grade (Gleason)
- ○ There was a change on rectal exam
- ○ Higher volume (more cancer on repeat biopsy)
- ○ Higher PSA
- ○ Spouse/partner recommended or encouraged treatment
- ○ I just decided to get treatment
- ○ Other: ______________________________

E. Factors Influencing Treatment Choice

9. When you initially were diagnosed and selected your inital treatment for prostate cancer, which of the following STRONGLY influenced your choice of treatment? *(Please choose up to three)*

- ○ Ability to receive treatment close to where I live
- ○ Ability of treatment to cure or control my cancer
- ○ Cost of treatment
- ○ My doctors' recommendation
- ○ Friends'/acquaintances' opinions, concerns or experiences
- ○ My spouse's or significant other's opinions, concerns or experiences
- ○ Other family members' opinions, concerns or experiences
- ○ The side effects of treatment
- ○ The treatment's effect on time away from work and other activities
- ○ Other: ______________________________

F. How Treatments and Side Effects Compare with Expectations

10. Please choose one response on each line:

	A lot worse	A little worse	About the same	A little better	A lot better
a. Compared to what you expected, how do you rate the effectiveness of the treatment so far?	○	○	○	○	○
b. Compared to what you expected, how do you rate the side effects of treatment so far?	○	○	○	○	○

G. General Health

11. Have you **ever** had any additional cancers diagnosed *(see below)*? Do not include prostate cancer or non-melanoma skin cancer.

○ No *(If No, please go to Question 12 on the next page)*

○ Yes **If Yes, please indicate which cancers you had.** *(Choose one response on each line)*

	Yes	No
a. Colon or rectal cancer	○	○
b. Lung cancer	○	○
c. Kidney cancer	○	○
d. Bladder cancer	○	○
e. Lymphoma or leukemia	○	○
f. Stomach cancer	○	○
g. Pancreatic cancer	○	○
h. Mouth or oral cancer	○	○
i. Melanoma	○	○
j. Liver cancer	○	○
k. Other cancer, please specify: ________________	○	○

12. Have you **ever** been told by a physician that you have any of the following problems with your breathing? *(Choose one response on each line)*

	Yes	No
a. Emphysema or chronic bronchitis	○	○
b. Asthma	○	○

13. During the **past 6 months**, how many times did you have each of the following? *(Choose one response on each line)*

	Never	Once	Twice	Three or more times
a. Pneumonia	○	○	○	○
b. Bronchitis for which you took antibiotics	○	○	○	○
c. Flu, with coughing	○	○	○	○

14. During the **past 6 months**, how often did you feel short of breath? *(Choose one response on each line)*

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
a. When lying down flat	○	○	○	○	○
b. When sitting or resting	○	○	○	○	○
c. When walking less than one block	○	○	○	○	○
d. When climbing one flight of stairs	○	○	○	○	○
e. When climbing several flights of stairs	○	○	○	○	○

15. Have you **ever** been told by a physician that you have any of the following problems related to your heart or circulation? *(Choose one response on each line)*

	Yes	No
a. Heart attack	○	○
b. Congestive heart failure	○	○
c. Angina	○	○

16. Have you **ever** been told by a physician that you have high blood pressure?

- ○ No *(If No, please go to Question 17)*
- ○ Yes
- ○ Don't know

If Yes, please answer the following:
During the **past 6 months**, did you take medication for your high blood pressure?

- ○ Yes, and the medication controlled my high blood pressure
- ○ Yes, but my blood pressure is still high
- ○ No, I did not take any medication for high blood pressure

17. Have you **ever** had any of the following operations or procedures related to your heart? *(Choose one response on each line)*

	Yes	No
a. Coronary artery bypass surgery (open heart surgery)	○	○
b. Coronary angioplasty (balloon or stent)	○	○
c. Heart catheterization (angiogram)	○	○
d. Exercise test (stress test)	○	○
e. Pacemaker/defibrillator insertion	○	○

18. During the **past 6 months**, how many times have you had any of the following problems related to your heart or circulation? *(Choose one response on each line)*

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
a. Chest pain or pressure when you exercise	○	○	○	○	○
b. Chest pain or pressure when resting	○	○	○	○	○
c. Ankles or legs that swell as the day goes on	○	○	○	○	○
d. Fainting or dizziness when you stand up	○	○	○	○	○

19. During the **past 6 months**, how often have you had pain in your back or joints? *(Choose one response on each line)*

	Never	Once or twice only	About once a month	Almost every week	More than once a week
a. That lasted at least half a day	○	○	○	○	○
b. That kept you from sleeping	○	○	○	○	○
c. That kept you from exercising or doing vigorous activities	○	○	○	○	○

20. Have you **ever** been told by a physician that you have any of the following problems with your feet or legs? *(Choose one response on each line)*

	Yes	No
a. Peripheral vascular disease (poor circulation in the legs)	○	○
b. Claudication (cramping in the calf during exercise)	○	○
c. Peripheral neuropathy (numbness, tingling, or burning in the feet)	○	○
d. Foot ulcers	○	○

21. Have you **ever** been told by a physician that you have any of the following problems? *(Choose one response on each line)*

	Yes	No
a. Stroke	○	○
b. Transient ischemic attack (TIA)	○	○
c. Epilepsy or seizure disorder	○	○
d. Parkinson's Disease	○	○
e. Migraines	○	○

22. Have you **ever** had any of the following problems? *(Choose one response on each line)*

	Yes	No
a. Paralysis or weakness on one side of the body	○	○
b. Lost the ability to talk	○	○

23. Have you **ever** been told by a physician that you have any of the following problems with your eyes? *(Choose one response on each line)*

	Yes	No
a. Cataracts	○	○
b. Glaucoma	○	○
c. Blurred vision (not correctable with eye glasses)	○	○
d. Retinopathy or macular degeneration	○	○

24. Have you **ever** had any of the following operations on your eyes? *(Choose one response on each line)*

	Yes, on ONE eye only	Yes, on BOTH eyes	No
a. Cataract surgery	○	○	○
b. Laser treatment for diabetes	○	○	○

25. Have you **ever** been told by a physician that you have diabetes?

○ No *(If No, please go to Question 26)*
○ Yes
○ Don't know

If Yes, please answer the following:
Do you take insulin shots?

○ No
○ Yes
○ Don't know

26. Have you **ever** been told by a physician that you have inflammatory bowel disease (Crohn's Disease, ulcerative colitis)?

○ No
○ Yes
○ Don't know

H. Activities of Daily Living

27. The following items are activities you might do during a **typical day**. Does your health now limit you in these activities? If so, how much? *(Choose one response on each line)*

	Yes, I am LIMITED a lot	Yes, I am LIMITED a little	No, I am NOT LIMITED at all
a. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	⬭	⬭	⬭
b. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	⬭	⬭	⬭
c. Lifting or carrying groceries	⬭	⬭	⬭
d. Climbing several flights of stairs	⬭	⬭	⬭
e. Climbing one flight of stairs	⬭	⬭	⬭
f. Bending, kneeling, or stooping	⬭	⬭	⬭
g. Walking more than a mile	⬭	⬭	⬭
h. Walking several hundred yards	⬭	⬭	⬭
i. Walking one hundred yards	⬭	⬭	⬭
j. Bathing or dressing yourself	⬭	⬭	⬭

Please go to the next page.

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I. Mood

28. These questions are about how you feel and how things have been going with you during the **past 4 weeks**. *For each question, please give the one answer that comes closest to the way you have been feeling.*

How much of the time during the **past 4 weeks**… *(Choose one response on each line)*

	None of the time	A little of the time	Some of the time	A good bit of the time	Most of the time	All of the time
a. Did you feel full of life?	○	○	○	○	○	○
b. Have you been very nervous?	○	○	○	○	○	○
c. Have you felt so down in the dumps that nothing could cheer you up?	○	○	○	○	○	○
d. Have you felt calm and peaceful?	○	○	○	○	○	○
e. Did you have a lot of energy?	○	○	○	○	○	○
f. Have you felt down-hearted and depressed?	○	○	○	○	○	○
g. Did you feel worn out?	○	○	○	○	○	○
h. Have you been happy?	○	○	○	○	○	○
i. Did you feel tired?	○	○	○	○	○	○

Please go to the next page.

29. During the **past 4 weeks** how often were the following statements true? *(Choose one response on each line)*

	None of the time	Some or a little of the time	Occasionally	Most or all of the time
a. I was bothered by things that usually don't bother me	○	○	○	○
b. I felt that I could not shake off the blues even with help from my family or friends	○	○	○	○
c. I had trouble keeping my mind on what I was doing	○	○	○	○
d. I felt depressed	○	○	○	○
e. I felt that everything I did was an effort	○	○	○	○
f. My sleep was restless	○	○	○	○
g. I was happy	○	○	○	○
h. I enjoyed life	○	○	○	○
i. I felt sad	○	○	○	○

J. Urinary Issues

30. Over the **past 4 weeks**, how often have you leaked urine? *(Choose one)*

- ○ More than once a day
- ○ About once a day
- ○ More than once a week
- ○ About once a week
- ○ Rarely or never

31. Which of the following best describes your urinary control during the **last 4 weeks**? *(Choose one)*

- ○ No urinary control whatsoever
- ○ Frequent dribbling
- ○ Occasional dribbling
- ○ Total control

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32. How many pads or adult diapers **per day** did you usually use to control leakage during the **last 4 weeks**? *(Choose one)*

- ○ None
- ○ 1 pad per day
- ○ 2 pads per day
- ○ 3 or more pads per day

33. How big a problem, if any, has each of the following been for you during the **last 4 weeks**? *(Choose one response on each line)*

	No problem	Very small problem	Small problem	Moderate problem	Big problem
a. Dripping or leaking urine	○	○	○	○	○
b. Pain or burning on urination	○	○	○	○	○
c. Bleeding with urination	○	○	○	○	○
d. Weak urine stream or incomplete emptying	○	○	○	○	○
e. Need to urinate frequently during the day	○	○	○	○	○

34. Overall, how big a problem has your urinary function been for you during the **last 4 weeks**? *(Choose one)*

- ○ No problem
- ○ Very small problem
- ○ Small problem
- ○ Moderate problem
- ○ Big problem

Please go to the next page.

K. Bowel Issues

35. How big a problem, if any, has each of the following been for you during the **last 4 weeks**? *(Choose one response on each line)*

	No problem	Very small problem	Small problem	Moderate problem	Big problem
a. Urgency to have a bowel movement	○	○	○	○	○
b. Increased frequency of bowel movements	○	○	○	○	○
c. Losing control of your stools	○	○	○	○	○
d. Bloody stools	○	○	○	○	○
e. Abdominal/pelvic/rectal pain	○	○	○	○	○

36. Overall, how big a problem have your bowel habits been for you during the **last 4 weeks**? *(Choose one)*

○ No problem
○ Very small problem
○ Small problem
○ Moderate problem
○ Big problem

Please go to the next page.

L. Sexual Issues

37. Do you have a sexual partner at this time?

- ⬭ Yes
- ⬭ No

Regardless of your answer to this question, please try to answer the questions below:

38. Do you currently use any of the following to help with problems with sexual function? *(Choose one response on each line)*

	Yes	No
a. Vacuum suction device	⬭	⬭
b. Penile injections (shots)	⬭	⬭
c. Pills, such as Viagra, Cialis, Levitra	⬭	⬭
d. Urethral pellets or suppositories (Muse)	⬭	⬭
e. Penile prosthesis (surgical implant)	⬭	⬭
f. Other (please specify): ______________________	⬭	⬭

Regardless of your answer to the question above, please report your actual experience in the ***last 4 weeks*** *for the following questions:*

39. How would you rate each of the following during the **last 4 weeks**? *(Choose one response on each line)*

	Very poor to none	Poor	Fair	Good	Very good
a. Your ability to have an erection	⬭	⬭	⬭	⬭	⬭
b. Your ability to reach orgasm (climax)	⬭	⬭	⬭	⬭	⬭

40. How would you describe the usual QUALITY of your erections during the **last 4 weeks**? *(Choose one)*

- None at all
- Not firm enough for any sexual activity
- Firm enough for masturbation and foreplay only
- Firm enough for intercourse

41. How would you describe the FREQUENCY of your erections during the **last 4 weeks**? *(Choose one)*

- I NEVER had an erection when I wanted one
- I had an erection LESS THAN HALF the time I wanted one
- I had an erection ABOUT HALF the time I wanted one
- I had an erection MORE THAN HALF the time I wanted one
- I had an erection WHENEVER I wanted one

42. Overall, how would you rate your ability to function sexually during the **last 4 weeks**? *(Choose one)*

- Very poor
- Poor
- Fair
- Good
- Very good

43. Overall, how big a problem has your sexual function or lack of sexual function been for you during the **last 4 weeks**? *(Choose one)*

- No problem
- Very small problem
- Small problem
- Moderate problem
- Big problem

M. Other Issues

44. How big a problem during the **last 4 weeks**, if any, has each of the following been for you? *(Choose one response on each line)*

	No problem	Very small problem	Small problem	Moderate problem	Big problem
a. Hot flashes	○	○	○	○	○
b. Breast tenderness/enlargement	○	○	○	○	○
c. Feeling depressed	○	○	○	○	○
d. Lack of energy	○	○	○	○	○
e. Change in body weight	○	○	○	○	○

45. Prostate cancer treatment may result in some other health problems. Have you developed any of the problems listed below after your prostate cancer treatment?

○ Yes *(If Yes, choose all that apply below)*
○ No *(If No, please go to Question 46 on the next page)*

	Yes	No
a. Urethral scarring/stricture/bladder neck contracture (blockage or narrowing of the tube which you urinate through)	○	○
b. Urinary incontinence procedure (artificial urinary sphincter, sling)	○	○
c. Fistula (abnormal connection between the urinary tract and bowel)	○	○
d. Urinary retention (inability to urinate)	○	○
e. Deep venous thrombosis/pulmonary embolism/ blood clots	○	○
f. Hernia	○	○
g. Fracture or broken bone	○	○
h. Shortening of the penis	○	○
i. Other, please specify: ______	○	○

N. Concerns Surrounding Impact of Prostate Cancer

46. Overall, how much of a burden is your having **prostate cancer** on you and your family in each of the following areas? *(Choose one response on each line)*

	Very large burden	Large burden	Feel neutral	Small burden	Very small burden	Not a burden at all
a. Our overall health	○	○	○	○	○	○
b. Our social activities	○	○	○	○	○	○
c. Our lifestyle	○	○	○	○	○	○
d. Our finances in general	○	○	○	○	○	○
e. Our finances due to the cost of my treatment	○	○	○	○	○	○
f. Our finances due to the other costs of health care for prostate cancer (such as visits to the doctor, etc.)	○	○	○	○	○	○
g. Our finances due to the cost of my health insurance because I have prostate cancer	○	○	○	○	○	○

47. How true has each of the following statements been for you during the **past 4 weeks**? *(Choose one response on each line)*

	Not at all	A little bit	Somewhat	Quite a bit	Very much
a. I am confident that my cancer is under control	○	○	○	○	○
b. I worry that my cancer might come back	○	○	○	○	○
c. I worry about my cancer spreading	○	○	○	○	○
d. I wonder whether the treatment I got for prostate cancer really worked	○	○	○	○	○
e. It worries me that I can't tell what is going on with my prostate cancer	○	○	○	○	○

48. Health: How true is each of the following for you? *(Choose one response on each line)*

	Not at all	A little bit	Somewhat	Quite a bit	Very much
a. My health could take a turn for the worse at any time	○	○	○	○	○
b. I sometimes worry about dying before my time	○	○	○	○	○
c. I worry about what my doctor will find next	○	○	○	○	○
d. I worry that changes in my medical condition will not be detected early	○	○	○	○	○
e. I am uneasy about the present state of my health	○	○	○	○	○
f. I live in fear that my PSA will rise	○	○	○	○	○

49. PSA: How true has each of the following statements been for you during the **past 4 weeks**? *(Choose one response on each line)*

	Not at all	A little bit	Somewhat	Quite a bit	Very much
a. I keep close track of my PSA	○	○	○	○	○
b. Knowing my PSA level is comforting to me	○	○	○	○	○

Please go to the next page.

50. Treatment choice: How true has each of the following statements been for you? *(Choose one response on each line)*

	Not at all	A little bit	Somewhat	Quite a bit	Very much
a. I wonder if I would have been better off with a different treatment	○	○	○	○	○
b. I sometimes wonder whether it was really worthwhile being treated at all	○	○	○	○	○
c. I sometimes feel the treatment I had was the wrong one for me	○	○	○	○	○
d. If I had it to do over, I would choose some other treatment	○	○	○	○	○
e. I sometimes wish I could change my mind about the kind of treatment I chose for my prostate cancer	○	○	○	○	○

51. Outlook: How true is each of the following statements for you? *(Choose one response on each line)*

	Not at all	A little bit	Somewhat	Quite a bit	Very much
a. I feel that my cancer has given me a better outlook on life	○	○	○	○	○
b. I feel that coping with cancer has made me a stronger person	○	○	○	○	○

Please go to the next page.

52. Decision: How true is each of the following statements for you? *(Choose one response on each line)*

	Not at all	A little bit	Somewhat	Quite a bit	Very much
a. I had all the information I needed when a treatment was chosen for my prostate cancer	○	○	○	○	○
b. My doctors told me the whole story about the effects of treatment	○	○	○	○	○
c. I knew the right questions to ask my doctor	○	○	○	○	○
d. I had enough time to make a decision about my treatment	○	○	○	○	○
e. I am satisfied with the choices I made in treating my prostate cancer	○	○	○	○	○
f. I would recommend the treatment I had to a close relative or friend	○	○	○	○	○

O. Social Support

53. People sometimes look to others for companionship, assistance, or other types of support. How often is each of the following kinds of support available to you if you need it? *(Choose one response on each line)*

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
a. Someone who can help you out if you need it - for example, by helping you get to the doctor or prepare your meals if you are unable to do it yourself	○	○	○	○	○
b. Someone to share your most private worries and fears with	○	○	○	○	○
c. Someone to love and make you feel wanted	○	○	○	○	○
d. Someone to do something enjoyable with or someone to have a good time with	○	○	○	○	○
e. Someone to give you good advice or give you information to help you understand a situation	○	○	○	○	○

54. Are you currently participating in any type of prostate cancer support group? *(Choose one response on each line)*

	Yes	No
a. In-person meetings	○	○
b. Online community	○	○
c. Other (please specify): ______	○	○

P. Satisfaction with Care

55. What is your overall feeling about the… *(Choose one response on each line)*

	Completely satisfied	Very satisfied	Somewhat satisfied	Mixed	Somewhat unsatisfied	Very unsatisfied	Completely unsatisfied
a. Effect of health care services in helping you deal with your cancer and maintain your well-being	○	○	○	○	○	○	○
b. Effect of cancer treatment in preventing cancer progression or recurrence	○	○	○	○	○	○	○
c. Quality of cancer care you have received	○	○	○	○	○	○	○
d. Effect of services in helping relieve symptoms or reduce problems	○	○	○	○	○	○	○
e. In an overall general sense, how satisfied are you with the cancer treatment you have received?	○	○	○	○	○	○	○

Q. Health Status

56. Under each heading, please fill in the ONE oval that best describes your health TODAY

Mobility

- ○ I have no problems walking
- ○ I have slight problems walking
- ○ I have moderate problems walking
- ○ I have severe problems walking
- ○ I am unable to walk

Self-Care

- ○ I have no problems washing or dressing myself
- ○ I have slight problems washing or dressing myself
- ○ I have moderate problems washing or dressing myself
- ○ I have severe problems washing or dressing myself
- ○ I am unable to wash or dress myself

Usual Activities *(e.g., work, study, housework, family or leisure activities)*

- ○ I have no problems doing my usual activities
- ○ I have slight problems doing my usual activities
- ○ I have moderate problems doing my usual activities
- ○ I have severe problems doing my usual activities
- ○ I am unable to do my usual activities

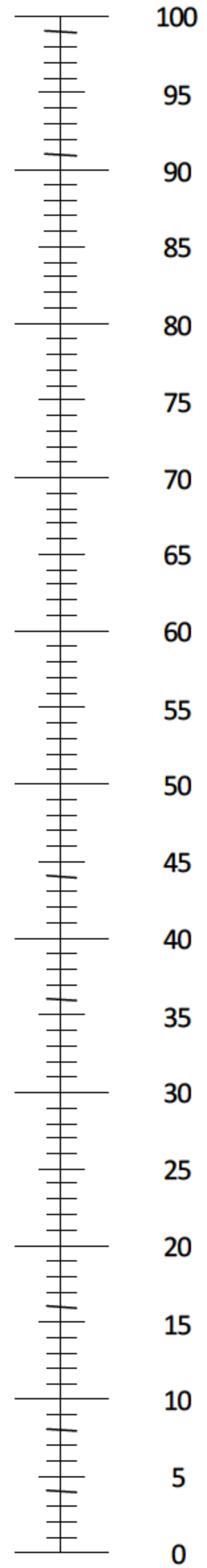
Pain/Discomfort

- ○ I have no pain or discomfort
- ○ I have slight pain or discomfort
- ○ I have moderate pain or discomfort
- ○ I have severe pain or discomfort
- ○ I have extreme pain or discomfort

Anxiety/Depression

- ○ I am not anxious or depressed
- ○ I am slightly anxious or depressed
- ○ I am moderately anxious or depressed
- ○ I am severely anxious or depressed
- ○ I am extremely anxious or depressed

Participant ID 0 0 0 0



57. We would like to know how good or bad your health is TODAY.

- This scale is numbered from 0 to 100.
- 100 means the best health you can imagine.
  0 means the worst health you can imagine.
- Mark an X on the scale to indicate how your health is TODAY.
- Now, please write the number you marked on the scale in the box below.

YOUR HEALTH TODAY = [ ]

Participant ID ___ 0 0 0 0 ___

R. Demographic Questions

58. What is your current employment status? *(Choose all that apply)*

- ○ Working full time
- ○ Working part time
- ○ Retired
- ○ Unemployed (or looking for work)

59. What is your current marital status? *(Choose one)*

- ○ Never married
- ○ Married or in a committed relationship
- ○ Separated
- ○ Divorced
- ○ Widowed

60. What type of health insurance or health care coverage do you currently have? *(Choose all that apply)*

- ○ No insurance
- ○ Private health insurance or HMO
- ○ Medicare
- ○ Veteran's Administration (VA) health care
- ○ Military health care (including CHAMPUS/TriCARE, CHAMP-VA)
- ○ Medicaid
- ○ Indian Health Service, Tribal Health Program, or Urban Indian Clinic
- ○ Don't know
- ○ Other, please specify: ______________________________

61. What is your current height? ___ feet ___ inches

62. What is your current weight? ___ pounds

63. What is your current waist size (on your pants or belt)? ___ inches

64. Do you smoke? *(Choose one)*

- ○ Yes, I do
- ○ No, but I did and I quit within the last 10 years
- ○ No, but I did and I quit more than 10 years ago
- ○ No, I never smoked

65. Are there any other things you would like to share about your experience with prostate cancer?

Thank you very much for your participation. Please mail the survey back in the enclosed postage paid envelope. If you have any questions, please contact: