Date completed: _____/_____/_____
(month) (day) (year)

BETTER
Health Survey™
Module 3

Name: _____

SECTION A: COLORECTAL (BOWEL) CANCER

Instructions: These questions are for both men and women.

For each of the following questions, please circle the number that corresponds to your response or fill in the blank as appropriate.

Have you ever been told by a healthcare professional that you had any of the following health conditions?

1. **Colorectal (bowel) cancer?** *Colorectal cancer is a type of cancer that develops in the colon and/or the rectum.* (Circle one number)

1. Yes ◯
2. No ◯ → ***go to Section B (page 3)***

2. **Did you receive surgery to remove the cancer?** (Circle one number)

1. Yes ◯
2. No ◯ → ***go to question 4***

3. **When was the date of your surgery to remove the cancer?** (Write the month and year in the space below)

	_____	_____
	(month)	(year)
e.g.	Feb	2005

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4. **When was the last time you had a carcinoembryonic antigen (CEA) test?** *Carcinoembryonic antigen (CEA) is a protein normally found in the blood of adults. A CEA test is usually a blood test that measures the amount of CEA protein in the blood. A sample of blood is taken by inserting a needle into the vein in your arm.* (Circle one number)

1. Less than 3 months ago
2. 3 months to less than 6 months ago
3. 6 months to less than 1 year ago
4. 1 year to less than 2 years ago
5. 2 or more years ago
6. Don't know
7. Never

5. **When was the last time you had a computerized tomography (CT or CAT) scan of your abdomen and chest?** *A computerized tomography (CT or CAT) scan is a procedure that uses a computer linked to an x-ray machine to make a series of detailed pictures of areas inside the body. A dye may be injected into a vein or swallowed to help the tissues and organs show up more clearly.* (Circle one number)

1. Less than 6 months ago
2. 6 months to less than 1 year ago
3. 1 year to less than 2 years ago
4. 2 years to less than 3 years ago
5. 3 or more years ago
6. Don't know
7. Never

6. **Have you ever been told by a healthcare professional that the cancer started in your rectum?** *The rectum is located between your colon and your anus. The area where cancer starts is also called the primary site.* (Circle one number)

1. Yes
2. No → ***go to Section B (page 3)***

7. **Did you receive pelvic radiation or radiation therapy to treat the rectal cancer?** *Radiation therapy uses a beam of radiation that is focused directly on the tumour.* (Circle one number)

1. Yes → ***go to Section B (page 3)***
2. No

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8. **When was the last time you had a rectosigmoidoscopy?** *A rectosigmoidoscopy is a test to examine the rectum and the lining of the lower part of your large intestine. It is carried out to see if there are any abnormal growths of tissue, also known as polyps, or to see if there is a tumour in its early stage.* (Circle one number)

1. Less than 6 months ago
2. 6 months to less than 1 year ago
3. 1 year to less than 2 years ago
4. 2 years to less than 3 years ago
5. 3 or more years ago
6. Don't know
7. Never

SECTION B: BREAST CANCER

Instructions: These questions are for women. If you are male, please go to Section C (page 5).

For each of the following questions, please circle the number that corresponds to your response as appropriate.

9. **Have you ever been told by a healthcare professional that you had breast cancer?** *Breast cancer is a type of cancer that forms in tissues of the breast.* (Circle one number)

1. Yes
2. No → ***go to Section E (page 8)***

10. **Have you had genetic testing for a mutation in the TP53 (Li-Fraumeni syndrome) or PTEN (Cowden and Bannayan-Riley-Ruvalcaba syndrome) genes?** *TP53 is inherited and predisposes someone to multiple cancers. PTEN is a gene that regulates a protein that helps with cell division and cell death.* (Circle one number)

1. Yes
2. No → ***go to question 12***
3. Don't know → ***go to question 12***

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11. Did you test positive for a TP53 or PTEN gene mutation? (Circle one number)

1. Yes ◯
2. No ◯
3. Don't know ◯

12. The table below provides a list of therapies that some breast cancer survivors may receive as part of their cancer treatment.

For each of the therapies in the table below, please circle the number that best indicates if you have ever been prescribed the therapy. For "Yes", circle the number 1; For "No", circle the number 2; and for "Don't Know", circle the number 3.

	Have you ever been prescribed the following medication or therapy?		
Medication or Therapy	**Yes**	**No**	**Don't know**
Tamoxifen (Nolvadex, Tamofen)	1 ◯	2 ◯	3 ◯
Raloxifene (Evista)	1 ◯	2 ◯	3 ◯
Anastrozole (Arimidex)	1 ◯	2 ◯	3 ◯
Letrozole (Femara)	1 ◯	2 ◯	3 ◯
Exemestane (Aromasin)	1 ◯	2 ◯	3 ◯
Buserelin Acetate (Suprefact)	1 ◯	2 ◯	3 ◯
Goserelin Acetate (Zoladex)	1 ◯	2 ◯	3 ◯
Leuprolide Acetate (Lupron, Lupron Depot, Eligard)	1 ◯	2 ◯	3 ◯

SECTION C: PROSTATE CANCER

Instructions: These questions are for men. If you are female, please go to Section D (page 8).

For each of the following questions, please circle the number that corresponds to your response as appropriate.

13. Have you ever had prostate cancer? *Prostate cancer is a type of cancer that forms in tissues of the prostate.* (Circle one number)

1. Yes
2. No → ***go to Section E (page 8)***

14. The table below provides a list of androgen deprivation therapies (ADTs) that some prostate cancer survivors may receive as part of their cancer treatment. *Androgen deprivation therapies are treatments done to suppress or block the production or action of male hormones.*

For each of the therapies in the table below, please circle the number that best indicates if you have ever been prescribed the therapy. For "Yes", circle the number 1; For "No", circle the number 2; and for "Don't Know", circle the number 3.

	Have you ever been prescribed the following medication or therapy?		
Medication or Therapy	**Yes**	**No**	**Don't know**
Abiraterone Acetate (Zytiga)	1	2	3
Apalutamide (Erleada)	1	2	3
Bicalutamide (Casodex)	1	2	3
Buserelin Acetate (Suprefact)	1	2	3
Darolutamide (Nubeqa)	1	2	3
Degarelix (Firmagon)	1	2	3
Enzalutamide (Xtandi)	1	2	3
Flutamide	1	2	3

	Have you ever been prescribed the following medication or therapy?		
Medication or Therapy	**Yes**	**No**	**Don't know**
Goserelin Acetate (Zoladex)	1 ◯	2 ◯	3 ◯
Leuprolide Acetate (Lupron, Lupron Depot, Eligard)	1 ◯	2 ◯	3 ◯
Nilutamide (Anandron)	1 ◯	2 ◯	3 ◯
Triptorelin Pamoate (Trelstar)	1 ◯	2 ◯	3 ◯

15. **When was the last time you had a prostate-specific antigen (PSA) test?** *Prostate-specific antigen, or PSA, is a protein produced by cells of the prostate gland. The PSA test measures the level of PSA in a man's blood.* (Circle one number)

1. Less than 6 months ago ◯
2. 6 months to less than 1 year ago ◯
3. 1 year to less than 2 years ago ◯
4. 2 years to less than 3 years ago ◯
5. 3 or more years ago ◯
6. Don't know ◯
7. Never ◯

SECTION D: BONE HEALTH FOR MEN AND WOMEN

Instructions: These questions are for both men and women.

For each of the following questions, please circle the number that corresponds to your response or fill in the blank as appropriate.

16. Are you currently being treated for osteoporosis? (Circle one number)

1. Yes ◯ ***→ go to Section E (page 8)***
2. No ◯
3. Don't know ◯

→ If you answered "No" or "Don't know" to question 16 and:

a) *are a woman who has had breast cancer AND are post-menopausal,* ***go to question 17***

b) *are a man who has had prostate cancer AND received androgen deprivation therapy,* ***go to question 17***

c) *do not meet criteria a) or b),* ***go to question 18***

17. When was the last time you had a bone density or DEXA scan? *A bone density or DEXA scan is a form of x-ray that is used to measure bone loss.* (Circle one number)

1. Less than 6 months ago
2. 6 months to less than 1 year ago
3. 1 year to less than 2 years ago
4. 2 years to less than 3 years ago
5. 3 or more years ago
6. Don't know
7. Never

18. Do you take any vitamin D supplements or calcium with vitamin D? (Circle one number)

1. Yes
2. No → ***go to question 20***
3. Don't know → ***go to question 20***

19. How many international units (IU) of vitamin D do you take each day? *Supplements are measured in international units (IU) and vitamin D supplements are typically sold in bottles of 400, 500, 600, or 1000 IU. Multivitamins usually include 200-600 IU of vitamin D.* (Write amount taken each day in the space provided or circle "Don't know" below)

_____ (IU) **OR** Don't know ☐

20. Do you take any calcium supplements? (Circle one number)

1. Yes
2. No → ***go to Section E (next page)***
3. Don't know → ***go to Section E (next page)***

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21. **How many milligrams of calcium do you take each day?** (Write amount taken each day in the space provided or circle "Don't know" below)

_____ (mg) **OR** Don't know ☐

SECTION E: GENERAL HEALTH

Instructions: These questions are for both men and women.

For each of the following questions, please circle the number that corresponds to your response as appropriate.

22. **When was the last time you had a medical check-up as part of your care following cancer treatment?** *A medical check-up may include a physical exam, bloodwork, or other tests that look for changes in your health. These check-ups may also include discussions about your mental health, sexual health, or other areas of concern after treatment ends.* (Circle one number)

1. Less than 6 months ago
2. 6 months to less than 1 year ago
3. 1 year to less than 2 years ago
4. 2 years to less than 3 years ago
5. 3 or more years ago
6. Don't know
7. Never

These next questions ask for your views about your health. Please circle the number that you think best describes how you feel. If you are unsure about how to answer a question, please give the best answer you can.

23. **Over the LAST 2 WEEKS, how often have you been bothered by the following problems?**

23a. Feeling nervous, anxious, or on edge (Circle one number)

1. Not at all
2. Several days
3. More than half the days
4. Nearly every day

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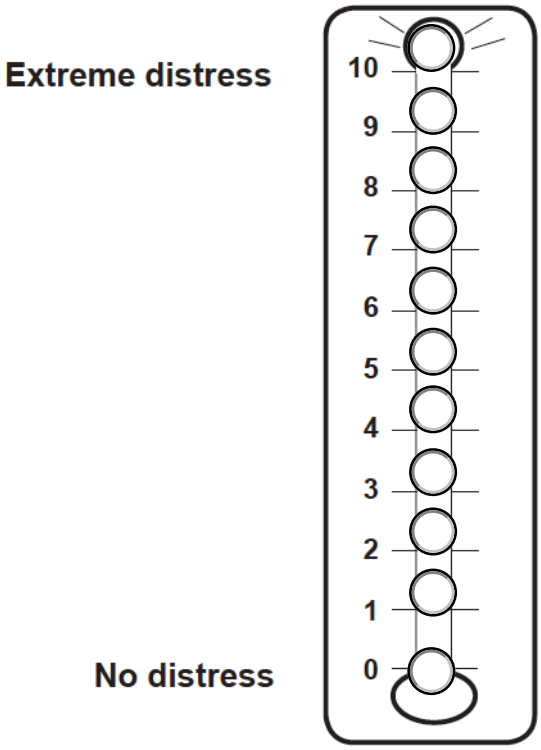
23b. Not being able to stop or control worrying (Circle one number)

1. Not at all
2. Several days
3. More than half the days
4. Nearly every day

24. Distress is an unpleasant experience of a mental, physical, social, or spiritual nature. It can affect the way you think, feel, or act. Distress may limit how well you function, interfere with your health decisions and self-care, and worsen your health. Symptoms of distress can include: sadness, fear, and helplessness; and poor sleep, appetite, or concentration.

Please circle the number (0 – 10) that best describes how much distress you have been experiencing in the past week including today.



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F: LONG-TERM EFFECTS OR SYMPTOMS

Instructions: These questions are for both men and women.

These next questions ask for your views about any long-term effects or symptoms that you may experience as a result of your cancer treatment. This information will help keep track of how you feel and how well you are able to do your usual activities.

Please circle the number that you think best describes any effects or symptoms that you are experiencing. If you are unsure about how to answer a question, please give the best answer you can.

25. To what extent are you experiencing long-term effects or symptoms as a result of cancer treatment? *Examples of long-term effects or symptoms include, but are not limited to, fatigue, pain, depression, anxiety, and changes in your level of awareness or thinking.* (Circle one number)

1. A great deal
2. Quite a bit
3. Somewhat
4. Very little
5. Not at all → ***go question 27***

26. How confident are you in your ability to look after the effects or symptoms you are experiencing as a result of your cancer treatment? Where 0 = not at all confident and 10 = extremely confident. (Circle one number)

☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
0	1	2	3	4	5	6	7	8	9	**10**

Not at all confident — **How confident** — **Extremely confident**

27. Do you have any concerns about your sexual health? *Common areas of concern include sexual function, body image, fertility, painful intercourse, and sexual intimacy.* (Circle one number)

1. Yes
2. No
3. Don't know

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G: POSSIBLE SYMPTOMS INDICATING RECURRENCE

Instructions: These questions are for both men and women.

These next questions ask about any new symptoms you may experience after cancer treatment.

Please circle the number that you think best describes any new symptoms that you are experiencing. If you are unsure about how to answer a question, please give the best answer you can.

28. The table below provides a list of common symptoms that may indicate cancer recurrence or that cancer has come back.

For each of the symptoms in the table below, please circle the number that best indicates if you are experiencing this new symptom. That is, you began experiencing the symptom after your cancer treatment. For "Yes", circle the number 1; For "No", circle the number 2; and for "Don't Know", circle the number 3. (Circle one number)

Note: The table below does not provide a complete list of all possible new symptoms that may indicate cancer recurrence. Please speak to your healthcare provider if you are experiencing any new symptoms.

	Are you experiencing the following new symptom?		
Symptom	**Yes**	**No**	**Don't know**
A cough that doesn't go away	1 ◯	2 ◯	3 ◯
A fever that doesn't go away	1 ◯	2 ◯	3 ◯
A mass or growth that you can feel	1 ◯	2 ◯	3 ◯
Anemia	1 ◯	2 ◯	3 ◯
Back pain with limb weakness	1 ◯	2 ◯	3 ◯
Change in sensation or reflexes	1 ◯	2 ◯	3 ◯
Changes in hearing, smell, vision, or taste	1 ◯	2 ◯	3 ◯
Enlarged liver	1 ◯	2 ◯	3 ◯

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	Are you experiencing the following new symptom?		
Symptom	**Yes**	**No**	**Don't know**
Enlarged lymph nodes (palpable lymphadenopathy)	1 ◯	2 ◯	3 ◯
Frequent headaches	1 ◯	2 ◯	3 ◯
Jaundice	1 ◯	2 ◯	3 ◯
Loss of appetite	1 ◯	2 ◯	3 ◯
Loss of bowel/bladder control	1 ◯	2 ◯	3 ◯
Memory loss	1 ◯	2 ◯	3 ◯
Nausea and vomiting	1 ◯	2 ◯	3 ◯
Pain of any kind that doesn't go away	1 ◯	2 ◯	3 ◯
Seizures	1 ◯	2 ◯	3 ◯
Severe fatigue	1 ◯	2 ◯	3 ◯
Shortness of breath (dyspnea)	1 ◯	2 ◯	3 ◯
Sweating	1 ◯	2 ◯	3 ◯
Unexplained weight loss	1 ◯	2 ◯	3 ◯

29. If there is anything else that you would like to comment on, or feel is important to include, please feel free to write in the space below.

_____

_____

_____

_____

_____

THANK YOU for completing the BETTER Health Survey™ Module 3!

Please return your survey to your healthcare provider.

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