University of Southampton

HORIZONS

Understanding the impact of cancer diagnosis and treatment on everyday life

Fourth Questionnaire: 18 month follow-up

Study ID | | | / | | | / | E | | | |

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Thank you for your valuable and continued involvement in this study.

Over 3,300 people across the UK are taking part in HORIZONS.

Your participation will help us to understand how a diagnosis of cancer and its treatment affects a person's everyday life and how this may change over time.

About this questionnaire

- This questionnaire is divided into 5 parts
- It will ask about your general health and wellbeing, how you have been feeling, and your experience of support, ongoing care and activities related to your health
- The information you give will remain confidential and will not be seen by your clinical team
- Please return your completed questionnaire in the FREEPOST envelope provided

You can also complete this questionnaire online

- It's easy to use and is laid out like the paper version
- Saves your progress as you go
- Based on your answers, it will show or hide follow-on questions if relevant
- You create your own secure log-in details

To do this or to find out more, please contact us:
HORIZONS@soton.ac.uk or 023 8059 6885

FAQ ***Why is this questionnaire so long?***

- HORIZONS covers a wide range of topics that people affected by cancer have said matter to them and want to know more about
- Please try to answer all the questions but feel free to skip questions if you don't think they apply to you
- You may also want to take breaks

Are my answers still useful for the study?

- Yes, even if you have not experienced problems, or feel you have moved on with your life since your diagnosis or treatment, we still want to know about your experiences
- You may also feel that you have other health conditions that may influence your answers, we consider all aspects of your health and so these answers are still very useful for us to understand your experiences

Why do some questions repeat?

- The questionnaire includes different sets of questions which measure different topics. Sometimes some questions will seem similar but unfortunately, we cannot change them as this will affect how we can interpret the results.
- You will also notice that some questions are repeated from our last questionnaires, this is important for us find out what has or has not changed since then.

Funded by
MACMILLAN CANCER SUPPORT

Part 1 – Your General Health & Well-Being

First, we would like to ask some questions about your current health and quality of life.

We would like to ask you about some things that can affect the **quality of people's lives**. Some of these questions may sound similar, but please be sure to answer each one.

Below is a scale rating from **'never'** to **'always'**. Please indicate how often each of these statements has been true for you in the **past four weeks**. (Please tick one answer for each question)

	Never	Seldom	Some times	About as often as not	Frequently	Very often	Always
You had the energy to do the things you wanted to do.	☐	☐	☐	☐	☐	☐	☐
You had difficulty doing activities that require concentrating.	☐	☐	☐	☐	☐	☐	☐
You were bothered by having a short attention span.	☐	☐	☐	☐	☐	☐	☐
You had trouble remembering things.	☐	☐	☐	☐	☐	☐	☐
You felt fatigued.	☐	☐	☐	☐	☐	☐	☐
You felt happy.	☐	☐	☐	☐	☐	☐	☐
You felt blue or depressed.	☐	☐	☐	☐	☐	☐	☐
You enjoyed life.	☐	☐	☐	☐	☐	☐	☐
You worried about little things.	☐	☐	☐	☐	☐	☐	☐
You were bothered by being unable to function sexually.	☐	☐	☐	☐	☐	☐	☐
You didn't have energy to do the things you wanted to do.	☐	☐	☐	☐	☐	☐	☐
You were dissatisfied with your sex life.	☐	☐	☐	☐	☐	☐	☐
You were bothered by pain that kept you from doing the things you wanted to do.	☐	☐	☐	☐	☐	☐	☐
You felt tired a lot.	☐	☐	☐	☐	☐	☐	☐
You were reluctant to start new relationships.	☐	☐	☐	☐	☐	☐	☐

You lacked interest in sex.	☐	☐	☐	☐	☐	☐	☐
Your mood was disrupted by pain or its treatment.	☐	☐	☐	☐	☐	☐	☐
You avoided social gatherings.	☐	☐	☐	☐	☐	☐	☐

	Never	Seldom	Some times	About as often as not	Frequently	Very often	Always
You were bothered by mood swings.	☐	☐	☐	☐	☐	☐	☐
You avoided your friends.	☐	☐	☐	☐	☐	☐	☐
You had aches or pains.	☐	☐	☐	☐	☐	☐	☐
You had a positive outlook on life.	☐	☐	☐	☐	☐	☐	☐
You were bothered by forgetting what you started to do.	☐	☐	☐	☐	☐	☐	☐
You felt anxious.	☐	☐	☐	☐	☐	☐	☐
You were reluctant to meet new people.	☐	☐	☐	☐	☐	☐	☐
You avoided sexual activity.	☐	☐	☐	☐	☐	☐	☐
Pain or its treatment interfered with your social activities.	☐	☐	☐	☐	☐	☐	☐
You were content with your life.	☐	☐	☐	☐	☐	☐	☐

The next set of questions asks specifically about the effects of your cancer or its treatment. Again, for each statement, indicate how often each of these statements has been true for you in the **past four weeks**. (Please tick **one** answer for each question).

	Never	Seldom	Some times	About as often as not	Frequently	Very often	Always
You appreciated life more because of having had cancer.	☐	☐	☐	☐	☐	☐	☐
You had financial problems because of the cost of cancer surgery or treatment.	☐	☐	☐	☐	☐	☐	☐
You worried that your family members were at risk of getting cancer.	☐	☐	☐	☐	☐	☐	☐

You realized that having had cancer helps you cope better with problems now.	☐	☐	☐	☐	☐	☐	☐
You were self-conscious about the way you look because of your cancer or its treatment.	☐	☐	☐	☐	☐	☐	☐
You worried about whether your family members might have cancer-causing genes.	☐	☐	☐	☐	☐	☐	☐

	Never	Seldom	Some times	About as often as not	Frequently	Very often	Always
You felt unattractive because of your cancer or its treatment.	☐	☐	☐	☐	☐	☐	☐
You worried about dying from cancer.	☐	☐	☐	☐	☐	☐	☐
You had problems with insurance because of cancer.	☐	☐	☐	☐	☐	☐	☐
You were bothered by hair loss from cancer treatment.	☐	☐	☐	☐	☐	☐	☐
You worried about cancer coming back	☐	☐	☐	☐	☐	☐	☐
You felt that cancer helped you to recognize what is important in life.	☐	☐	☐	☐	☐	☐	☐
You felt better able to deal with stress because of having had cancer.	☐	☐	☐	☐	☐	☐	☐
You worried about whether your family members should have genetic tests for cancer.	☐	☐	☐	☐	☐	☐	☐
You had money problems that arose because you had cancer.	☐	☐	☐	☐	☐	☐	☐
You felt people treated you differently because of changes to your appearance due to your cancer or its treatment.	☐	☐	☐	☐	☐	☐	☐

You had financial problems due to a loss of income as a result of cancer.	☐	☐	☐	☐	☐	☐	☐
Whenever you felt a pain, you worried that it might be cancer again.	☐	☐	☐	☐	☐	☐	☐
You were preoccupied with concerns about cancer.	☐	☐	☐	☐	☐	☐	☐

Under each heading, please tick the ONE box that best describes your health TODAY.

MOBILITY

- ☐ I have no problems in walking about
- ☐ I have slight problems in walking about
- ☐ I have moderate problems in walking about
- ☐ I have severe problems in walking about
- ☐ I am unable to walk about

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

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

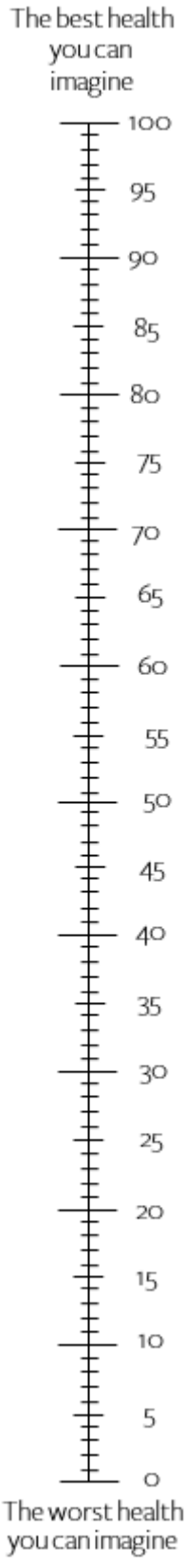
This scale is numbered from **0** to **100**.

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 = ☐



Part 2 – Your Experiences of Support, Ongoing Care and Activities

We would like to find out more about the types of support and assistance you have available to you. We would also like to ask you about your experiences of your treatment and any ongoing activities related to your health and also about how people cope and manage their health.

For each of the following questions, please tick the box that corresponds to your confidence that you can do the tasks regularly **at the present time**.

	Not at all Confident 1	2	3	4	5	6	7	8	9	Totally Confident 10
How confident are you that you can keep the fatigue caused by having had cancer and/or cancer treatment from interfering with the things you want to do?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
How confident are you that you can keep the physical discomfort or pain of having had cancer and/or cancer treatment from interfering with the things you want to do?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
How confident are you that you can keep the emotional distress caused by having had cancer and/or cancer treatment from interfering with the things you want to do?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
How confident are you that you can keep any other symptoms or health problems you have from interfering with the things you want to do?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
How confident are you that you can do the different tasks and activities needed to manage your cancer and/or cancer treatment so as to reduce your need to see a doctor?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
How confident are you that you can do things other than just taking medication to reduce how much having had cancer and/or cancer treatment affects your everyday life?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
How confident are you that you can access information about cancer and any effects of the diagnosis and treatment?	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

How confident are you that you can access people to help and support you when you have problems caused by cancer and/or cancer treatment?	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
How confident are you that you can deal by yourself with the problems cancer and/or cancer treatment has caused?	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
How confident are you to contact your doctor about problems caused by cancer and/or cancer treatment?	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐
How confident are you that you can get support with problems caused by cancer/treatment from health and/or social care professionals?	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐

People's problems sometimes affect their ability to do certain day-to-day tasks in their lives. To rate your problems look at each section and determine on the scale provided how much your problem impairs your ability to carry out the activity.

Work: Because of my cancer, my **ability to work** is impaired.
If you are retired or choose not to have a job for reasons unrelated to your cancer, please tick 'N/A'.

0 1 2 3 4 5 6 7 8 ☐

Not at all — Slightly — Definitely — Markedly — Very Severely — N/A

Home Management: Because of my cancer, my **home management** (cleaning, tidying, shopping, cooking, looking after home or children, paying bills, etc.) is impaired

0 1 2 3 4 5 6 7 8

Not at all — Slightly — Definitely — Markedly — Very Severely

Social Leisure Activities: Because of my cancer, my **social leisure activities** (With other people, e.g. parties, pubs, outings, entertaining etc.) are impaired

0 1 2 3 4 5 6 7 8

Not at all — Slightly — Definitely — Markedly — Very Severely

Private Leisure Activities: Because of my cancer, my **private leisure activities** (Done alone, e.g. reading, gardening, sewing, hobbies, walking etc.) are impaired

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly		Very Severely

Family and Relationships: Because of my cancer, my ability to form and maintain **close relationships** with others, including the people that I live with, is impaired

0	1	2	3	4	5	6	7	8
Not at all		Slightly		Definitely		Markedly		Very Severely

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? (Please tick one box on each line)

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Emotional / informational Support:					
Someone you can count on to listen to you when you need to talk	☐	☐	☐	☐	☐
Someone to give you information to help you understand a situation	☐	☐	☐	☐	☐
Someone to give you good advice about a crisis	☐	☐	☐	☐	☐
Someone to confide in or talk to about yourself or your problems	☐	☐	☐	☐	☐
Someone whose advice you really want	☐	☐	☐	☐	☐
Someone to share your most private worries and fears with	☐	☐	☐	☐	☐
Someone to turn to for suggestions about how to deal with a personal problem	☐	☐	☐	☐	☐
Someone who understands your problems	☐	☐	☐	☐	☐
Tangible Support:					
Someone to help you if you were confined to bed	☐	☐	☐	☐	☐
Someone to take you to the doctor if you needed it	☐	☐	☐	☐	☐
Someone to prepare your meals if you were unable to do it yourself	☐	☐	☐	☐	☐
Someone to help with daily chores if you were sick	☐	☐	☐	☐	☐
Affectionate Support:					
Someone who shows you love and affection	☐	☐	☐	☐	☐
Someone to love and make you feel wanted	☐	☐	☐	☐	☐
Someone who hugs you	☐	☐	☐	☐	☐
Positive Social Interaction:					
Someone to have a good time with	☐	☐	☐	☐	☐
Someone to get together with for relaxation	☐	☐	☐	☐	☐
Someone to do something enjoyable with	☐	☐	☐	☐	☐

Additional Item:					
Someone to do things with to help you get your mind off things	☐	☐	☐	☐	☐

For each of the questions, please indicate which response on the scale you most agree with.

In the past 4 weeks, how easy / difficult has it been to…

	Very easy	Easy	Neither easy nor difficult	Difficult	Very difficult	Not applicable
…learn about your health problem(s)?	☐	☐	☐	☐	☐	☐
…learn what foods you should eat to stay healthy?	☐	☐	☐	☐	☐	☐
…find information on the medications that you have to take?	☐	☐	☐	☐	☐	☐
…understand changes to your treatment plan?	☐	☐	☐	☐	☐	☐
…understand the reasons why you are taking some medicines?	☐	☐	☐	☐	☐	☐
…find sources of medical information that you trust?	☐	☐	☐	☐	☐	☐
…understand advice from different healthcare providers?	☐	☐	☐	☐	☐	☐

In the past 4 weeks, how much of a problem has it been for you to…

	Not at all	A little	Somewhat	Quite a bit	Very much
…make or keep your medical appointments?	☐	☐	☐	☐	☐
…schedule and keep track of your medical appointments?	☐	☐	☐	☐	☐
…make or keep appointments with **different** healthcare providers?	☐	☐	☐	☐	☐

In the past 4 weeks, how much of a problem has it been for you to…

	Not at all	A little	Somewhat	Quite a bit	Very much
…monitor your health behaviors, e.g., tracking exercise, foods you eat, or medicines you take?	☐	☐	☐	☐	☐
…monitor your health condition, e.g., weighing yourself, checking blood pressure, or checking blood sugar?	☐	☐	☐	☐	☐

In the past 4 weeks, how bothered have you been by…

	Not at all	A little	Somewhat	Quite a bit	Very much
…feeling dependent on others for your healthcare needs?	☐	☐	☐	☐	☐
…others reminding you to do things for your health like take your medicine, watch what you eat, or schedule medical appointments?	☐	☐	☐	☐	☐
…your healthcare needs creating tension in your relationships with others	☐	☐	☐	☐	☐
…others not understanding your health situation	☐	☐	☐	☐	☐

In general**,** how much do you agree/disagree with the following?

	Strongly agree	Agree	Disagree	Strongly disagree	Not applicable
I have problems with different healthcare providers not communicating with each other about my medical care	☐	☐	☐	☐	☐
I have to see too many different specialists for my health problem(s) or illness(es)	☐	☐	☐	☐	☐
I have problems filling out forms related to my healthcare	☐	☐	☐	☐	☐
I have problems getting appointments at times that are convenient for me	☐	☐	☐	☐	☐
I have problems getting appointments with a specialist	☐	☐	☐	☐	☐
I have to wait too long at my medical appointments	☐	☐	☐	☐	☐
I have to wait too long at the pharmacy for my medicine	☐	☐	☐	☐	☐

In the following questions, self-management refers to all of those tasks and activities that you have to do specifically for your health problem(s) or illness(es) in order to stay healthy. This can include taking medicine, going to medical appointments, monitoring your health, diet, and exercise.

In the past 4 weeks, how much has your self-management interfered with your…

	Not at all	A little	Somewhat	Quite a bit	Very much
…work (include work at home)?	☐	☐	☐	☐	☐
…family responsibilities?	☐	☐	☐	☐	☐

…daily activities?	☐	☐	☐	☐	☐
…hobbies and leisure activities?	☐	☐	☐	☐	☐
…ability to spend time with family and friends?	☐	☐	☐	☐	☐
…ability to travel for work or vacation?	☐	☐	☐	☐	☐

In the past 4 weeks, how often did your self-management make you feel…

	Never	Rarely	Sometimes	Often	Always
…angry?	☐	☐	☐	☐	☐
…preoccupied?	☐	☐	☐	☐	☐
…depressed?	☐	☐	☐	☐	☐
…worn out?	☐	☐	☐	☐	☐
…frustrated?	☐	☐	☐	☐	☐

Are you experiencing any particular problems relating to your cancer and/or its treatment?
If yes, please can you describe them here:

If you are experiencing problems, have you found ways to manage them?
If yes, please can you describe them here:

Have you received any support in managing problems following your treatment?
If yes, please can you describe it here:

Do you think additional support would be helpful?
If yes, please can you describe here:

Do you have caring responsibilities for children aged under 18 years?

☐ Yes ☐ No

If '**Yes'**, how many children (aged under 18 years) do you care for?

☐ children

Do you look after, or give any help or support to family, friends, neighbours or others? This may be because of either long-term physical or mental health disability, or problems relating to old age.

☐ Yes ☐ No

Does anyone look after, or give you help or support? This may be because of either a long-term physical or mental health disability, or problems relating to old age.

☐ Yes ☐ No

If '**Yes'**: Is this formal paid care? (e.g. nurse, home-help etc.):

☐ Yes ☐ No

Is this informal unpaid care? (e.g. relative, neighbour, friend etc.):

☐ Yes ☐ No

Part 3 – How You Have Been Feeling

In this section, we would like to know more about any symptoms you might be experiencing and how you have been feeling.

Please answer all of the questions yourself by circling the number that best applies to you. There are no "right" or "wrong" answers. The information that you provide will remain strictly confidential.

	Not at all	A little	Quite a bit	Very much
1. Do you have any trouble doing strenuous activities like carrying a heavy shopping bag or a suitcase?	1	2	3	4
2. Do you have any trouble taking a long walk?	1	2	3	4
3. Do you have any trouble taking a short walk outside of the house?	1	2	3	4
4. Do you need to stay in bed or a chair during the day?	1	2	3	4
5. Do you need help with eating, dressing, washing yourself or using the toilet?	1	2	3	4

During the **past week:**

	Not at all	A little	Quite a bit	Very much
6. Were you limited in doing either your work or other daily activities?	1	2	3	4
7. Were you limited in pursuing your hobbies or other leisure time activities?	1	2	3	4
8. Were you short of breath?	1	2	3	4
9. Have you had pain?	1	2	3	4
10. Did you need to rest?	1	2	3	4
11. Have you had trouble sleeping?	1	2	3	4
12. Have you felt weak?	1	2	3	4
13. Have you lacked appetite?	1	2	3	4
14. Have you felt nauseated?	1	2	3	4
15. Have you vomited?	1	2	3	4
16. Have you been constipated?	1	2	3	4
17. Have you had diarrhea?	1	2	3	4
18. Were you tired?	1	2	3	4
19. Did pain interfere with your daily activities?	1	2	3	4

20. Have you had difficulty in concentrating on things, like reading a newspaper or watching television?	1	2	3	4

During the past week:

	Not at all	A little	Quite a bit	Very much
21. Did you feel tense?	1	2	3	4
22. Did you worry?	1	2	3	4
23. Did you feel irritable?	1	2	3	4
24. Did you feel depressed?	1	2	3	4
25. Have you had difficulty remembering things?	1	2	3	4
26. Has your physical condition or medical treatment interfered with your family life?	1	2	3	4
27. Has your physical condition or medical treatment interfered with your social activities?	1	2	3	4
28. Has your physical condition or medical treatment caused you financial difficulties?	1	2	3	4

For the following questions please circle the number between 1 and 7 that best applies to you

29. How would you rate your overall health during the past week?

1	2	3	4	5	6	7
Very Poor						Excellent

30. How would you rate your overall quality of life during the past week?

1	2	3	4	5	6	7
Very Poor						Excellent

Patients sometimes report that they have the following symptoms or problems.
Please indicate the extent to which you have experienced these symptoms or problems, please answer by circling the number that best applies to you.

During the past week:

	Not at all	A little	Quite a bit	Very much
31. Have you had swelling in one or both legs?	1	2	3	4
32. Have you felt heaviness in one or both legs?	1	2	3	4
33. Have you had pain in your lower back and / or pelvis?	1	2	3	4
34. When you felt the urge to pass urine, did you have to hurry to get to the toilet?	1	2	3	4
35. Have you passed urine frequently?	1	2	3	4
36. Have you had leaking of urine?	1	2	3	4
37. Have you had pain or a burning feeling when passing urine?	1	2	3	4
38. When you felt the urge to move your bowels, did you have to hurry to get to the toilet?	1	2	3	4
39. Have you had any leakage of stools?	1	2	3	4
40. Have you been troubled by passing wind?	1	2	3	4
41. Have you had cramps in your abdomen?	1	2	3	4
42. Have you had a bloated feeling in your abdomen?	1	2	3	4
43. Have you had tingling or numbness in your hands or feet?	1	2	3	4
44. Have you had aches or pains in your muscles or joints?	1	2	3	4
45. Have you lost hair?	1	2	3	4
46. Has food and drink tasted differently from usual?	1	2	3	4
47. Have you felt physically less attractive as a result of your disease or treatment?	1	2	3	4
48. Have you felt less feminine as a result of your disease or treatment?	1	2	3	4
49. Have you had hot flushes?	1	2	3	4
50. Did you have night sweats?	1	2	3	4
51. Did you have headaches?	1	2	3	4
52. Have you had any skin problems (e.g. itchy, dry)?	1	2	3	4

During the past four weeks:

	Not at all	A little	Quite a bit	Very much
53. To what extent were you interested in sex?	1	2	3	4
54. To what extent were you sexually active?	1	2	3	4

Answer these questions only if you have been sexually active during the past four weeks:

	Not at all	A little	Quite a bit	Very much
55. Has your vagina felt dry during sexual activity?	1	2	3	4
56. Has your vagina felt short and / or tight?	1	2	3	4
57. Have you had pain during sexual intercourse or other sexual activity?	1	2	3	4
58. Was sexual activity enjoyable for you?	1	2	3	4
59. Have you been satisfied with your ability to reach an orgasm?	1	2	3	4
60. If applicable: Have you had a change in the ability to reach an orgasm since you received treatment for cancer?	No	Yes		

During the past four weeks:

	Not at all	A little	Quite a bit	Very much
61. Have you worried about your health in the future?	1	2	3	4
62. How much has your disease been a burden to you?	1	2	3	4
63. How much has your treatment been a burden to you?	1	2	3	4
64. If applicable: Have you been concerned about your ability to have children?	1	2	3	4
65. If applicable: Have you had problems at your work or place of study due to the disease?	1	2	3	4
66. If applicable: Have you worried about not being able to continue working or your education?	1	2	3	4

During the past week:

	Not at all	A little	Quite a bit	Very much
67. Have you suffered from pain and tingling in your feet/toes?	0	1	2	3
68. Have you suffered from pain and tingling in your hands/fingers?	0	1	2	3
69. Have you suffered from numb or cold feet or toes?	0	1	2	3
70. Have you suffered from numb or cold hands or fingers?	0	1	2	3
71. Have you suffered from ringing in your ears?	0	1	2	3
72. Have you suffered from reduced hearing?	0	1	2	3
73. If applicable: Was the ringing present before your cancer treatment?	No	Yes		
74. If applicable: Was the hearing loss present before your cancer treatment?	No	Yes		

For the following questions, please circle the number that best corresponds to your views:

To what extent does worry about your cancer spill over or intrude into your other thoughts and activities?

0	1	2	3	4	5	6	7	8	9	10
Not at all										A great deal

How often have you worried about the possibility that your cancer might come back after treatment?

0	1	2	3	4
None of the time	Rarely	Occasionally	Often	All the time

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https://campaign.optum.com/content/optum/en/optum-outcomes/what-we-do/health-surveys/sf-12v2-health-survey.html

Measure references:
Ware, J.E., Kosinski, M. & Keller, S.D. (1996). A 12 Item Short Form Health Survey: Construction of Scales and Preliminary Tests of Reliability and Validity. Medical Care, 34(3), 220-233

Ware, J.E., Kosinski, M., Turner-Bowker, D.M., & Gandek, B. (2002). How to score Version 2 of the SF-12 Health Survey (with a supplement documenting Version 1). Lincoln RI: QualityMetric Incorporated

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Please answer the following questions about your general health:

	Yes	No
In general, do you have any health problems that require you to limit your activities?	☐	☐
Do you need someone to help you on a regular basis?	☐	☐
In general, do you have any health problems that require you to stay at home?	☐	☐
In case of need, can you count on someone close to you?	☐	☐
Do you regularly use a stick, walker or wheelchair to get about?	☐	☐

Your Menstrual Cycle

We would like to know whether or not you have gone through the menopause. The menopause is an event in a woman's life marked by the end of menstrual periods. By providing this information you will help us understand your answers to other questions we ask in this questionnaire. If you do not wish to answer, please leave this question blank.

How would you describe your current menstrual cycle (periods) status? (Please tick one)

☐ Pre-menopause (regular periods in the last 3 months and no change in the frequency of periods)

☐ Early menopause transition (have had periods in the last 3 months but noticed a change in the frequency of these periods)

☐ Late menopausal transition (at least 3 months in a row without a period but for less than 12 months)

☐ Post-menopause (at least 12 months in a row without a period)

If 'Post-menopause', was your menopause: (Please tick one)

- ☐ Spontaneous ("natural")
- ☐ Surgical (removal of both ovaries)
- ☐ Due to chemotherapy or radiation therapy; reason for therapy: _____
- ☐ Other (please explain): _____

Part 4 – About You

In this section, we would like to know a little about yourself and if anything has changed since the first questionnaire.

Are you **currently:** (Please tick **one**)

☐ Single
☐ In a relationship

What is your current domestic status? (Please tick **one**)

☐ Never married and/or never in a registered same-sex civil partnership
☐ In a relationship (with the same or opposite sex) but with no marital status
☐ Married
☐ Separated, but still legally married
☐ Divorced
☐ Widowed
☐ In a registered same-sex civil partnership
☐ Separated, but still legally in a same-sex civil partnership
☐ Formerly in a same-sex civil partnership which is now legally dissolved
☐ Surviving partner from a same-sex civil partnership

Which of the following people usually live in your household with you? (Please tick **all that apply**)

☐ Wife / husband / partner / civil partner / cohabitee
☐ Child(ren)
☐ Parent(s)
☐ Friend(s)
☐ Other (please specify): _____
☐ None of the above, I live alone

Have any first degree relative(s) of yours (parent, brother / sister or child) ever been diagnosed with cardiac health problems (e.g. heart attack or myocardial infarction, heart failure, high blood pressure)?

☐ Yes ☐ No ☐ Unknown

Part 5 – Your Comments

Is there anything else that has happened in your life (other than your cancer and its treatment) that you think we should know about which may have affected your health and wellbeing?

Is there anything else we have not asked about that you think we ought to know?

We offer the option to complete our follow-up questionnaires on paper or online.
For the next follow-up questionnaire, which of these methods would you prefer?

☐ Paper ☐ Online

Today's Date

Please fill in the date you completed this questionnaire:

D	D	/	M	M	/	Y	Y	Y	Y

Thank you very much for your participation

Thank you very much for your help. We really value the time you have taken to complete this questionnaire.

Your participation is very helpful to us.

It is possible that you may have found some of these questions have raised issues for you which may be upsetting. If you have any concerns following the completion of this questionnaire we recommend that you seek support from your health care providers, such as your GP or specialist nurse, or through the helpline provided by Macmillan Cancer Support, who can be contacted on 0808 808 0000.

Please be aware that what you have written is not always read and analysed until some time after we receive the questionnaire. Questionnaires and notes are not read by your health care team.

Please return this form in the FREEPOST envelope provided.

If you would like further information or have any queries about this study, please contact the HORIZONS Research Team on 023 8059 6885 or email HORIZONS@soton.ac.uk.

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