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Cancer Center

PREVALANCE OF SELF REPORTED LYMPHEDEMA IN PATIENTS WITH ENDOMETRIAL CANCER

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DATE COMPLETED:

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INSTRUCTIONS: PLEASE CHECK THE APPROPRIATE BOX OR FILL IN THE BLANK AS INDICATED.

ABOUT YOU

This first set of questions is about you and your treatment for endometrial cancer.

1. **About how tall are you without shoes?**

   _____ Feet __ __ Inches

2. **About how much do you weigh without shoes?**

   __ __ __ Pounds

3. **Did you receive radiation treatment after your surgery for endometrial cancer?**

   ☐ No ☐ Yes ☐ Don't know

4. **Did you receive chemotherapy after your surgery for endometrial cancer?**

   ☐ No ☐ Yes ☐ Don't know

5. **Has a doctor, nurse, or other health professional ever told you that you have any of the following?** (Mark one response on each line.)

	NO	YES	DON'T KNOW
Diabetes or high blood sugar……	☐	☐	☐
Heart failure or congestive heart failure……	☐	☐	☐
Kidney disease or kidney failure……..	☐	☐	☐

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6. **Has a doctor, nurse, or other health professional told you that your endometrial cancer has recurred?**

☐ No ☐ Yes ☐ Don't know

If Yes, when? ____ /_____

Month / Year

Lymphedema is swelling that can occur anywhere on a person's body. The swelling occurs when lymph fluid cannot drain properly because the lymphatic system is blocked or damaged.

The next few questions ask about lymphedema in your lower body, which includes anything below the navel (belly button).

7. **Before your surgery, did a doctor, nurse, or other health professional talk to you about the possibility of developing lymphedema in your lower body as a result of your surgery for endometrial cancer?**

☐ No ☐ Yes ☐ Don't know

8. **Has a doctor, nurse, or other health professional ever told you that you have lymphedema in your lower body?**

☐ No ☐ Yes ☐ Don't know

If Yes, when were you first told that you have lymphedema in your lower body?

☐ Before your surgery for endometrial cancer

☐ After your surgery for endometrial cancer

☐ Don't know

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Have you ever done any of the following to manage lymphedema in your lower body?	NO	YES	If yes, are you still doing this? NO	YES
Worn compression stockings……..	☐	☐	☐	☐
Worn bandages……	☐	☐	☐	☐
Done exercises such as "calf pumps"	☐	☐	☐	☐
Done self-massage, also called "manual lymphatic drainage"……	☐	☐	☐	☐
Other, please specify: _____	☐	☐	☐	☐

YOUR LOWER BODY

The following statements are about sensations you may have on one or both sides of your lower body.

Please mark one box for each statement that best describes how your lower body felt on average in the past 4 weeks. If you have one of these sensations on both sides of your lower body, describe the side that seems to be affected the most.

	Not at all	A Little bit	Somewhat	Quite a bit	Very much
9. The skin on my leg feels tight……..	☐	☐	☐	☐	☐
10. The skin above my ankle feels tight……	☐	☐	☐	☐	☐
11. My leg feels heavy……..	☐	☐	☐	☐	☐
12. I have pain or discomfort in my leg……	☐	☐	☐	☐	☐
13. My leg is noticeably smaller when I get out of bed in the morning……..	☐	☐	☐	☐	☐

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14. I have swelling in my foot…….	☐	☐	☐	☐	☐
15. I have swelling around my ankle……	☐	☐	☐	☐	☐
16. I have swelling in my lower leg (including knee)……...	☐	☐	☐	☐	☐
17. I have swelling in my upper leg……...	☐	☐	☐	☐	☐
18. I have swelling in my buttocks……	☐	☐	☐	☐	☐
19. I have swelling in my hip (on the side below the waist)…….	☐	☐	☐	☐	☐
20. I have swelling below my stomach (below the belly button)……	☐	☐	☐	☐	☐
21. I have swelling in my genital area……	☐	☐	☐	☐	☐

YOUR WELL-BEING

We are interested in some things about you and your health. Please answer all of the questions yourself by marking the box that best applies to you. There is no "right" or "wrong" answer. The information that you provide will remain strictly confidential.

	Not at all	**A Little bit**	**Quite a bit**	**Very much**
22. Do you have any trouble doing strenuous activities like carrying a heavy shopping bag or suitcase?.....……..	☐	☐	☐	☐
23. Do you have any trouble taking a long walk?.....	☐	☐	☐	☐
24. Do you have any trouble taking a short walk outside of the house?.....	☐	☐	☐	☐

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25. Do you need to stay in bed or a chair during the day?.....	☐	☐	☐	☐
26. Do you need help with eating, dressing, washing yourself or using the toilet?.....….	☐	☐	☐	☐

During the past week:

	Not at all	A Little bit	Quite a bit	Very much
27. Were you limited in doing either your work or other daily activities?.....	☐	☐	☐	☐
28. Were you limited in pursuing your hobbies or other leisure time activities?.....	☐	☐	☐	☐
29. Were you short of breath?.....	☐	☐	☐	☐
30. Have you had pain?.....	☐	☐	☐	☐
31. Did you need to rest?.....	☐	☐	☐	☐
32. Have you had trouble sleeping?.....	☐	☐	☐	☐
33. Have you felt weak?.....	☐	☐	☐	☐
34. Have you lacked appetite?.....	☐	☐	☐	☐
35. Have you felt nauseated?.....	☐	☐	☐	☐
36. Have you vomited?.....	☐	☐	☐	☐
37. Have you been constipated?.....	☐	☐	☐	☐
38. Have you had diarrhea?.....	☐	☐	☐	☐
39. Were you tired?.....	☐	☐	☐	☐
40.Did pain interfere with your daily activities?.....	☐	☐	☐	☐

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During the past week:

	Not at all	A Little bit	Quite a bit	Very much
41. Have you had difficulty in concentrating on things like reading a newspaper or watching television?.....	☐	☐	☐	☐
42. Did you feel tense?.....	☐	☐	☐	☐
43. Did you worry?.....	☐	☐	☐	☐
44. Did you feel irritable?.....	☐	☐	☐	☐
45. Did you feel depressed?.....	☐	☐	☐	☐
46. Have you had difficulty remembering things?.....	☐	☐	☐	☐
47. Has your physical condition or medical treatment interfered with your <u>family</u> life?.....	☐	☐	☐	☐
48. Has your physical condition or medical treatment interfered with your <u>social</u> activities?.....	☐	☐	☐	☐
49. Has your physical condition or medical treatment caused you financial difficulties?.....	☐	☐	☐	☐

For the following items, please mark the number between 1 and 7 that best applies to you.

50. How would you rate your overall <u>health</u> during the past week?

☐ ☐ ☐ ☐ ☐ ☐ ☐

1 2 3 4 5 6 7

Very poor Excellent

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

☐ ☐ ☐ ☐ ☐ ☐ ☐

1 2 3 4 5 6 7

Very poor Excellent

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Patients sometimes report that they have the following symptoms or problems. Please indicate the extent to which you have experienced these symptoms or problems.

During the past week:

	Not at all	A Little bit	Quite a bit	Very much
52. Have you had swelling in one or both legs?	☐	☐	☐	☐
53. Have you felt heaviness in one or both legs?	☐	☐	☐	☐
54. Have you had pain in your lower back and/or pelvis?	☐	☐	☐	☐
55. When you felt the urge to pass urine, did you have to hurry to get to the toilet?	☐	☐	☐	☐
56. Have you passed urine frequently?	☐	☐	☐	☐
57. Have you had leaking of urine?	☐	☐	☐	☐
58. Have you had pain or a burning feeling when passing urine?	☐	☐	☐	☐
59. When you felt the urge to move your bowels, did you have to hurry to get to the toilet?	☐	☐	☐	☐
60. Have you had any leakage of stools?	☐	☐	☐	☐
61. Have you been troubled by passing wind?	☐	☐	☐	☐
62. Have you had cramps in your abdomen?	☐	☐	☐	☐
63. Have you had a bloated feeling in your abdomen?	☐	☐	☐	☐
64. Have you had tingling or numbness in your hands or feet?	☐	☐	☐	☐
65. Have you had aches or pains in your muscles or joints?	☐	☐	☐	☐

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During the past week:

	Not at all	A Little bit	Quite a bit	Very much
66. Have you lost hair?.....	☐	☐	☐	☐
67. Has food and drink tasted differently from usual?	☐	☐	☐	☐
68. Have you felt physically less attractive as a result of your disease or treatment?.....	☐	☐	☐	☐
69. Have you felt less feminine as a result of your disease or treatment?.....	☐	☐	☐	☐

During the past 4 weeks:

	Not at all	A Little bit	Quite a bit	Very much
70. To what extent were you interested in sex?.....	☐	☐	☐	☐
71. To what extent were you sexually active?.....	☐	☐	☐	☐

Answer these questions only if you have been sexually active during the past 4 weeks:

72.Has your vagina felt dry during sexual activity?.....	☐	☐	☐	☐
73. Has your vagina felt short and/or tight?.....	☐	☐	☐	☐
74. Have you had pain during sexual intercourse or other sexual activity?.....	☐	☐	☐	☐
75. Was sexual activity enjoyable for you?.....	☐	☐	☐	☐

THANK YOU!