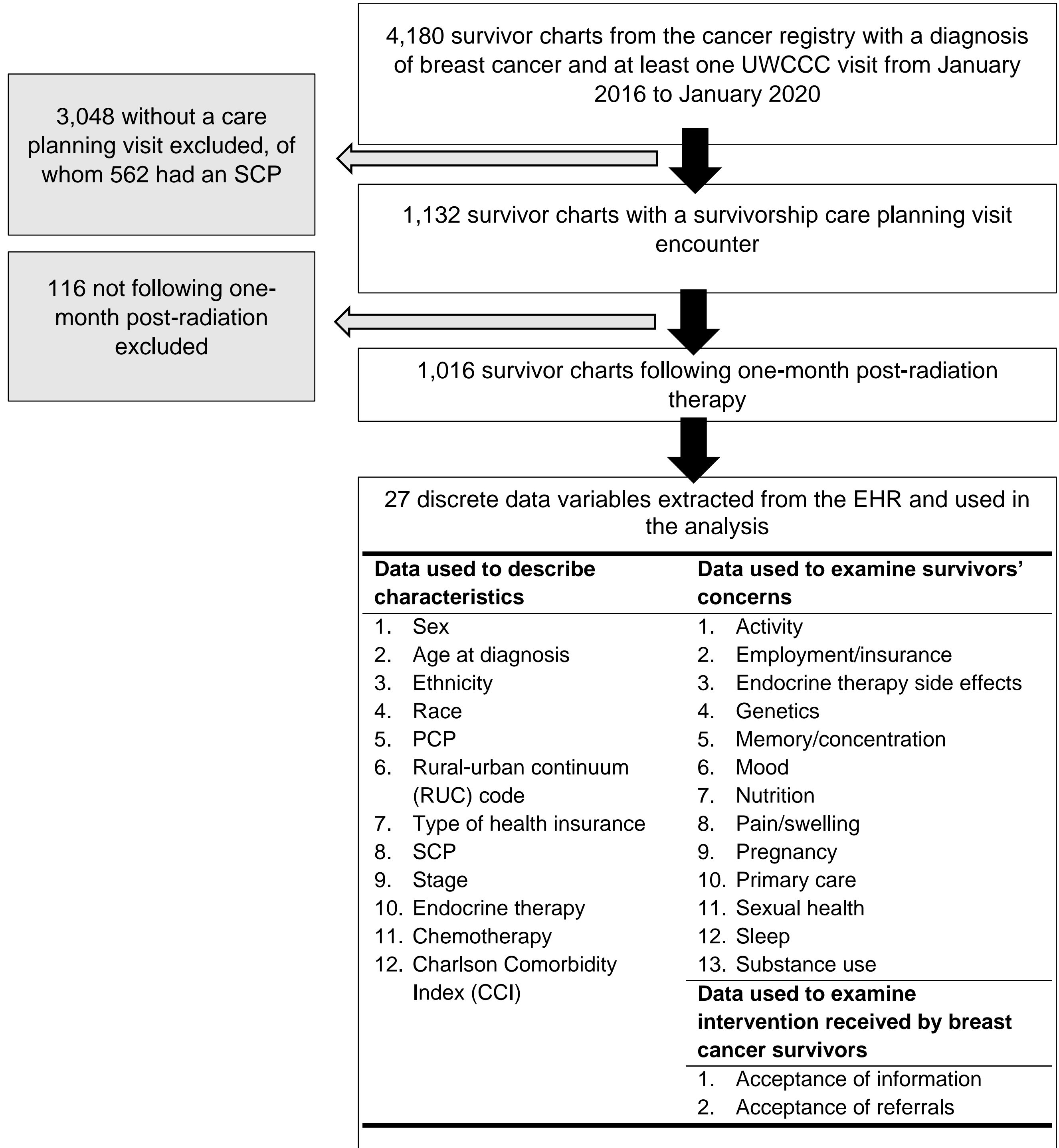
Supplement 1. Survivor Population Flowchart



Supplement 2. Survivorship Questionnaire

Patient Name

DOB:

MR #

University of Wisconsin Hospitals and Clinics
University of Wisconsin Medical Foundation
BREAST CENTER SURVIVORSHIP QUESTIONNAIRE

Date: ___________________________________

Welcome to the UW Health Breast Center Survivorship Program!
At this visit, we will review your treatment history, talk about what to watch for in the future, and review your follow-up schedule for the next several years.

Please answer the following questions-your answers will help us offer you resources to support a smooth transition back to your normal activities. Please mark **ALL** areas that are true for you.

1. **Nutrition**

☐ I would like to lose weight.
☐ I would like to gain weight.
☐ I would like to improve my diet.
☐ I have no concerns in this area.

☐ I would like more information.
☐ I want a referral to a dietitian.
☐ I need nothing further.

2. **Activity**

☐ I have problems with weakness.
☐ I have problems with fatigue.
☐ I get short of breath with activity.
☐ I want to increase my physical activity.
☐ I have no concerns in this area.

☐ I would like more information.
☐ I want to talk to a specialist about my activity level.
☐ I need nothing further.

3. **Mood**

☐ I feel nervous or worried.
☐ I feel sad or depressed.
☐ I have lost interest in things I used to enjoy.
☐ I notice changes in my relationships with others (partner, children, friends) due to cancer.
☐ I have no concerns in this area.

☐ I would like more information.
☐ I want a referral to a health psychologist.
☐ I need nothing further.

4. **Sleep**

☐ I have trouble falling asleep.
☐ I have trouble staying asleep.
☐ I feel very sleepy during the day.
☐ My legs are restless when I try to sleep.
☐ I have no concerns in this area.

☐ I would like more information.
☐ I want a referral for a sleep evaluation.
☐ I need nothing further.

5. **Sexual Health**

☐ I am bothered by hot flashes.
☐ I am having vaginal dryness or pain with sex.
☐ I have no or low interest in sex
☐ I have concerns about body image.
☐ I have no concerns in this area.

☐ I would like more information.
☐ I want a referral to a sexual health provider.
☐ I need nothing further.

6. **Employment/Insurance**

☐ I have financial problems due to cancer.
☐ I have insurance issues or problems because of cancer.
☐ I am unable to work because of cancer.
☐ I have difficulty working due to cancer.
☐ I have no concerns in this area.

☐ I would like more information.
☐ I want to meet with a Breast Center navigator.
☐ I need nothing further.

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Patient Name
DOB:
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BREAST CENTER SURVIVORSHIP QUESTIONNAIRE

7. **Pain & Swelling**

- ☐ I am having pain. Where? ________________________
  How bad is your pain? 1 2 3 4 5 6 7 8 9 10
- ☐ I have neuropathy (numbness or tingling in the hands, feet or arm). Where? __________________
- ☐ I have trouble moving a part of my body. Where? ______________________________________
- ☐ I have swelling (in breast, armpit, or arm). Where? _______________________________
- ☐ I have no concerns in this area.
- ☐ I would like more information.
- ☐ I want a referral to a specialist.
- ☐ I need nothing further.

8. **Pregnancy**

- ☐ I would like to get pregnant.
- ☐ I want to be sure NOT to get pregnant.
- ☐ I am not worried about pregnancy.
- ☐ I wo[illegible]ike more information.
- ☐ I wa[illegible] referral.
- ☐ I nee[illegible]othing further.

9. **Memory & Concentration**

- ☐ I have trouble concentrating.
- ☐ I have trouble multi-tasking.
- ☐ My memory is poor.
- ☐ My thinking is slow.
- ☐ I have no concerns in this area.
- ☐ I would [illegible]ore information
- ☐ [illegible]d not[illegible]ther.

10. **Additional Concerns**

- ☐ I would like to quit smoking.
- ☐ I would like to cut down on my drinking
- ☐ I need help finding a primar[illegible]ovider.
- ☐ I would like more inform[illegible] abo[illegible] risk of fu[illegible]ncers fo[illegible]r my family members
- ☐ Other concern(s) we [illegible]ot ask abo[illegible]please list: ____
  ____
- ☐ I would [illegible] more information.
- ☐ I need [illegible]ing further.

11. **Please add a chec[illegible]k in each [illegible] how satisfied you are with your knowledge of:**

	Extrem[illegible] satisfied	Somewhat satisfied	Neither satisfied or unsatisfied	Somewhat unsatisfied	Extremely unsatisfied
The ca[illegible]diag[illegible]	☐	☐	☐	☐	☐
Th[illegible]eatment you r[illegible]ved	☐	☐	☐	☐	☐
[illegible]r understandin[illegible] possible side effects	☐	☐	☐	☐	☐
You[illegible]n for f[illegible] follow-up	☐	☐	☐	☐	☐

Signature o[illegible]ient/Representative ___________________________________Date:_________ Time: ________AM/PM

If signed by pers[illegible]her than the patient, print name and state relationship and authority to do so.

Print Name: ____Relationship: _________________________________

Patient is: ☐ Minor ☐ Incompetent / Incapacitated
Legal Authority: ☐ Legal Guardian ☐ Parent of Minor ☐ Health Care Agent ☐ Other _______________

Reviewed by: ____ Date: ____________ Time: _________AM/PM

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