ReFLECT Study

Instructions:
Thank you for agreeing to participate in the study, Relationships among Cognitive Function, Lifestyle, and Exercise after Cancer Treatment (ReFLECT). This questionnaire will ask you a series of questions about yourself. There are no right or wrong answers and all we ask is that you provide responses that are as honest and accurate as possible. All responses are completely confidential and will not be used in any way that could link your responses to you.

Exercise Psychology Laboratory

ILLINOIS
UNIVERSITY OF ILLINOIS AT URBANA-CHAMPAIGN
Please complete the following information about yourself. The information you provide will be used for research purposes only and will be held in **strictest confidence**.

1. What is your current Marital Status? (circle one)
   - Married
   - Partnered/Significant Other
   - Single
   - Divorced/Separated
   - Widowed

2. What is your current Age? __________ 

3. Number of Children __________

4. What is your current Employment Status? (please select only one)
   - Full time – working at least 35 hours/week
   - Part time – working less than 35 hours/week
   - Retired, working part-time
   - Retired, not working at all
   - Laid off or unemployed
   - Full time homemaker
   - Other, Specify: ______________________________________________

5. If you are working, what is your Present Occupation (the one you work most hours per week)?
   __________________________________________________________________

6. Years in present occupation: __________ years

7. If you are employed, how many days of work have you missed in the past month because you were sick?
   __________

8. Race (circle one)
   - American Indian/Alaska Native
   - Asian
   - Native Hawaiian or Other Pacific Islander
   - Black or African American
   - White
   - More Than One Race
   - Unknown or Not Reported

9. Ethnicity (circle one)
   - Hispanic or Latino
   - Not Hispanic or Latino
10. Education (Circle highest level attained)
   1. Less than 9th grade
   2. 9th grade (Jr. High)
   3. Partial High School
   4. High School Graduate
   5. 1-3 years of College or 2 yr College/Vocational/Technical school graduate
   6. College/University Graduate
   7. Masters Degree
   8. PhD or Equivalent

11. Annual Household Income (circle one)
   1. $25,000 to $34,999
   2. $35,000 to $49,999
   3. $50,000 to $74,999
   4. $75,000 to $99,999
   5. $100,000 to $149,999
   6. $150,000 or more

12. Do you have a psychological or social characteristic that may prevent you from accurately answering the study questions, completing the cognitive tests, or using the activity monitor (if applicable)? Please choose one.
   Yes
   No

13. Have you used any cognitive training or assessment tools (e.g., BrainBaseline, Lumosity, etc.)?
   Yes
   No

   If yes, what tool(s) have you used?
Please answer the following questions about your breast cancer history.

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. When did you receive your first diagnosis of breast cancer?</td>
<td>Month Year</td>
</tr>
<tr>
<td>2. What was your age at diagnosis?</td>
<td>__________</td>
</tr>
<tr>
<td>3. What was the stage of your breast cancer?</td>
<td>1 2 3 4 Don’t know</td>
</tr>
<tr>
<td>4. Was your breast cancer estrogen receptor positive?</td>
<td>Yes No Don’t know</td>
</tr>
<tr>
<td>5. Are you currently receiving chemotherapy for your breast cancer?</td>
<td>Yes No</td>
</tr>
<tr>
<td>6. Have you ever received chemotherapy for breast cancer?</td>
<td>Yes No</td>
</tr>
<tr>
<td>a. If yes, for how many months?</td>
<td>__________</td>
</tr>
<tr>
<td>b. Months since last dose of chemotherapy</td>
<td>__________</td>
</tr>
<tr>
<td>7. Are you currently receiving radiation therapy for your breast cancer?</td>
<td>Yes No</td>
</tr>
<tr>
<td>8. Have you ever received radiation therapy for your breast cancer?</td>
<td>Yes No</td>
</tr>
<tr>
<td>a. If yes, for how many months?</td>
<td>__________</td>
</tr>
<tr>
<td>b. Months since last dose of radiation therapy</td>
<td>__________</td>
</tr>
<tr>
<td>9. Did you have surgery for breast cancer?</td>
<td>Yes No</td>
</tr>
<tr>
<td>a. If yes, what surgery was done?</td>
<td>________________________</td>
</tr>
<tr>
<td>b. Months since your surgery for breast cancer</td>
<td>__________</td>
</tr>
<tr>
<td>10. Which of the following medications are you currently taking?</td>
<td></td>
</tr>
<tr>
<td>- anastrozole (Arimidex®)</td>
<td>tamoxifen (Nolvadex®)</td>
</tr>
<tr>
<td>- letrozole (Femara®)</td>
<td>toremifene (Fareston®)</td>
</tr>
<tr>
<td>- exemestane (Aromasan®)</td>
<td>raloxifene (Evista®)</td>
</tr>
<tr>
<td>- fulvestrant (Faslodex®)</td>
<td>Not taking any of these</td>
</tr>
<tr>
<td>a. Length of time you have been taking above medication</td>
<td>__________</td>
</tr>
<tr>
<td>11. Have you experienced menopause?</td>
<td>Yes No Don’t know</td>
</tr>
<tr>
<td>12. Which of the following describes your menopausal status at the time of diagnosis?</td>
<td>Pre-menopausal Post-menopausal Not sure</td>
</tr>
</tbody>
</table>
13. Have you been diagnosed with a breast cancer recurrence? (By recurrence we mean the breast cancer coming back in the same breast or a new breast cancer in either breast)
   a. If yes, how many times
       ○ Yes ☐ No ☐ Don’t know
   b. If yes, when?
       __________ __________ __________ __________
       Month     Year     Month     Year
   c. What was the stage of your diagnosis?
       ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ Don’t know

14. Have you ever been diagnosed with any other type of cancer?
   a. If yes, what type __________________________________________
   b. If yes, when?
       __________ __________ __________ __________
       Month     Year     Month     Year

15. Arthritis (rheumatoid and/or osteoarthritis) □ Yes □ No
16. Osteoporosis □ Yes □ No
17. Asthma □ Yes □ No
18. Chronic obstructive pulmonary disease (COPD), acquired respiratory distress syndrome (ARDS) or emphysema □ Yes □ No
19. Angina □ Yes □ No
20. Congestive heart failure (or heart disease) □ Yes □ No
21. Heart attack (myocardial infarct) □ Yes □ No
22. Neurological disease (such as Multiple Sclerosis or Parkinson’s) □ Yes □ No
23. Stroke or TIA □ Yes □ No
24. Dementia or organic brain syndrome □ Yes □ No
25. Peripheral vascular disease (for example blockages in the arteries of your neck, arms and/or legs) □ Yes □ No

General Health History

Has your doctor diagnosed you with any of the following conditions?

15. Arthritis (rheumatoid and/or osteoarthritis) □ Yes □ No
16. Osteoporosis □ Yes □ No
17. Asthma □ Yes □ No
18. Chronic obstructive pulmonary disease (COPD), acquired respiratory distress syndrome (ARDS) or emphysema □ Yes □ No
19. Angina □ Yes □ No
20. Congestive heart failure (or heart disease) □ Yes □ No
21. Heart attack (myocardial infarct) □ Yes □ No
22. Neurological disease (such as Multiple Sclerosis or Parkinson’s) □ Yes □ No
23. Stroke or TIA □ Yes □ No
24. Dementia or organic brain syndrome □ Yes □ No
25. Peripheral vascular disease (for example blockages in the arteries of your neck, arms and/or legs) □ Yes □ No
26. Diabetes type I or II □ Yes □ No

27. Upper gastrointestinal disease (ulcer, hiatal hernia, reflux) □ Yes □ No

28. Tremors □ Yes □ No

If yes, which part(s) of your body are affected by tremors (e.g., hands, arms, face, voice)?

________________________________________________________

29. Depression □ Yes □ No

30. Anxiety or panic disorders □ Yes □ No

31. Visual impairment (such as cataracts, glaucoma, macular degeneration) □ Yes □ No

32. Hearing impairment (very hard of hearing, even with hearing aids) □ Yes □ No

33. Degenerative disc disease (back disease, spinal stenosis, or severe chronic back pain) □ Yes □ No

34. Obesity □ Yes □ No

35. What is your current weight in pounds? ______________

36. What is your current height in inches? ______________

37. Which of the following is true regarding your current weight in comparison to your pre-cancer weight?

I weigh less now. I weight about the same. I weight more now.

38. Are you satisfied with your current weight?

Yes No

a. If no, how much weight would you like to gain or lose?

Gain (+) ________ pounds Lose (-) ________ pounds Neither

39. How many cups of any caffeinated beverage do you drink daily (soft drinks, coffee, tea, etc.)? __________

40. Do you currently smoke?

Yes No

a. If yes, how many packs a day do you smoke? __________
41. Did you smoke previously?
   Yes    No
   a. If you are a former smoker, how many years has it been since you quit? ________

42. Do you drink alcohol?
   Yes    No
   a. If yes, how many days per week do you drink alcohol? ______________
   b. How many drinks containing alcohol do you have on a typical day when you are drinking? ____________