

Cancer Exercise Recovery Questionnaire

Name: _____

Date: _____

1. Gender

Male

Female

3. Years since diagnosis _____

4. Type of Cancer

Head and Neck Cancer

Breast

Cervix

Colorectal

Leukemia

Lymphoma

Liver

Lung

Melanoma

Ovary

Pancreas

Prostate

Stomach

Testis

Other

5. Type of Treatment (Check all that apply)

Chemotherapy What class of agents did you receive? _____

Radiation

Surgery

Hormonal Therapy

Immunology Therapy

Bone Marrow Transplant

Gene Therapy

Vaccine Therapy

None

Other, Please specify:

Do you do anything different now than before the cancer treatment? Such as; losing balance, inability to reach things, bumping into things, not having the energy or endurance level to complete tasks. Please explain: _____

Do you have reason to believe that any of your medications alters your ability to fight infections?

6. Side Effect(s) that you experience since treatment (Check all that apply)

Anemia

Anxiety

Body image changes

Bruising easily

Cardiomyopathy

Cognitive dysfunction

Decreased bone density (fractures)

Depression

Mild Fatigue

Extreme Fatigue

Gastrointestinal (i.e. ulceration, intestinal motility)

Increased infections

Interstitial edema

Liver (i.e. cytotoxic lesions, hepatic fibrosis, cirrhosis)

Lymphedema

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- Muscular weakness (including decreased range of motion and imbalances)
- Nausea
- Pericarditis

Pulmonary (i.e. pulmonary fibrosis, dyspnea)

- Sleep disturbances
- Thyroid dysfunction
- Urinary incontinence
- Vision (i.e. blurred)
- Vomiting
- Weight gain. How much _____
- Weight loss. How much _____
- Other, please specify:

Before Diagnosis

7. Where you physically active on a regular basis before being diagnosed with cancer?

- Yes
- No

8. If yes:

Number of days per per week _____

Length of time per workout _____

Type(s) of activities _____

Intensity (Low, Moderate, High) _____

Aerobic exercise _____

Weights _____

Stretching _____

Balance _____

During Treatment

10. Did you maintain a regular exercise program while undergoing treatment?

- Yes

- No

11. If yes, did exercise alleviate any or all of your symptoms? Please explain.

12. If you were unable to continue exercising during your treatment, please explain why.

Following Treatment

13. At any time from the time of diagnosis to the end of your treatment, were you given instructions to exercise?

- Yes
- No

14. If yes, by a health care professional or friend?

- Health Care Professional/ fitness professional :

- Friend

Guidelines given:

15. At any point in your treatment were you given information by your health care provider about starting to exercise?

- Yes
- No

16. Did a health care provider give you any education about how your side effects from having cancer or cancer treatments may impact your ability to become involved in exercise? For example: If you have had breast surgery and have had lymph nodes removed, did your health care provider explain the risk of lymphedema associated with specific types of physical exercise?

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Yes

No

Please explain:

17. Following your treatment, did you participate in an exercise program?

Yes

No

18. If yes, was the exercise program structured? Please explain. (Include location)

19. Were you able to exercise at the same intensity as you had before receiving treatment?

Yes

No

20. What type of physical activity did you do? _____

21. What benefits do you feel you get from engaging in physical activity? _____

22. What information do you feel should be included in a post cancer treatment program? _____

23. Additional Comments:
