

CANCER SURVIVORS

Survivorship Care Plan

Sex: Female Male

Race: Caucasian African American Asian/Pacific Islander
 Hispanic/Latino/a Mixed Race Other

Age at Diagnosis: _____ Current Age: _____

Highest Education Level: Grade School High School Some College
 College Degree (BA, BS) Graduate School (MD, PhD, JD)

1. What type of cancer did you have? (Check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Melanoma |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Multiple Myeloma |
| <input type="checkbox"/> Breast | <input type="checkbox"/> Non-melanoma skin cancers |
| <input type="checkbox"/> Cervical | <input type="checkbox"/> Ovarian |
| <input type="checkbox"/> Colorectal | <input type="checkbox"/> Pancreatic |
| <input type="checkbox"/> Endometrial | <input type="checkbox"/> Penile |
| <input type="checkbox"/> Esophageal | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Head and Neck: Tongue, Lip,
Oropharynx, Nasopharynx | <input type="checkbox"/> Sarcoma |
| <input type="checkbox"/> Kidney | <input type="checkbox"/> Stomach |
| <input type="checkbox"/> Leukemia | <input type="checkbox"/> Thymoma or Thymic Carcinoma |
| <input type="checkbox"/> Liver | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Lung | <input type="checkbox"/> Other Cancer |
| <input type="checkbox"/> Lymphoma | <input type="checkbox"/> None |

SURGERY

2. Did you undergo surgery for this cancer? Yes No

2a. IF YES: Which surgical procedure did you have? (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Abdominal surgeries | <input type="checkbox"/> Removal of the Testicle(s) (Orchiectomy) |
| <input type="checkbox"/> Amputation (Removal of a Limb) | <input type="checkbox"/> Removal of the Thyroid |
| <input type="checkbox"/> Head and Neck Surgeries | <input type="checkbox"/> Splenectomy (Removal of Spleen) |
| <input type="checkbox"/> Lung Resection | <input type="checkbox"/> Surgery for Rectal or Anal Cancer |
| <input type="checkbox"/> Lymph Node Removal/Sentinel Node Biopsy | <input type="checkbox"/> Surgery Involving the Brain or Spinal Cord |
| <input type="checkbox"/> Mastectomy or Lumpectomy | <input type="checkbox"/> Surgery to Remove Female Reproductive
Organs (hysterectomy, oophorectomy) |
| <input type="checkbox"/> Removal of a Section of the Bowel | <input type="checkbox"/> Surgery to Remove the Stomach (Gastrectomy) |
| <input type="checkbox"/> Removal of the Bladder (Cystectomy) | <input type="checkbox"/> Whipple Procedure (pancreatectomy) |
| <input type="checkbox"/> Removal of the Esophagus (esophagectomy) | <input type="checkbox"/> Other Surgeries Not Listed |
| <input type="checkbox"/> Removal of the Kidney (Nephrectomy) | |
| <input type="checkbox"/> Removal of the Prostate (Prostatectomy) | |

Describe other surgery not listed above:

CHEMOTHERAPY

3. Did you receive medication, IV (administered into your vein) or oral (by mouth), for treatment of this cancer (including chemotherapy, biologic therapy and hormone therapy)?

No Yes

3a. IF YES: What chemotherapies did you receive? (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Chemotherapy & Biologic Therapies | <input type="checkbox"/> Chlorambucil (Leukeran®) |
| <input type="checkbox"/> 6-Mercaptopurine (Purinethol® , 6-MP) | <input type="checkbox"/> Cisplatin (Platinol®) |
| <input type="checkbox"/> 6-Thioguanine (6-TG, Thioguanine Tabloid®) | <input type="checkbox"/> cladribine (2-CDA, Leustatin®) |
| <input type="checkbox"/> Altretamine (Hexalen®, HMM) | <input type="checkbox"/> Cyclophosphamide (Cytoxan®, Neosar®) |
| <input type="checkbox"/> Azathiopurine | <input type="checkbox"/> Cytarabine (Cytosar-U®, Ara-C) |
| <input type="checkbox"/> Bexarotene (Targretin®) | <input type="checkbox"/> Dacarbazine (DTIC) |
| <input type="checkbox"/> Bleomycin (Blenoxane®) | <input type="checkbox"/> Dactinomycin (Cosmegen®) |
| <input type="checkbox"/> Bortezomib (Velcade®) | <input type="checkbox"/> Daunorubicin (Cerubidine®, daunomycin) |
| <input type="checkbox"/> Busulfan (Myleran®) | <input type="checkbox"/> Dexamethasone (decadron) |
| <input type="checkbox"/> capecitabine (Xeloda®) | <input type="checkbox"/> Docetaxel (Taxotere®) |
| <input type="checkbox"/> Carboplatin (Paraplatin®) | <input type="checkbox"/> Doxorubicin (Adriamycin®, Rubex®) |
| <input type="checkbox"/> Carmustine (BCNU, BiCNU) | |

- Epirubicin (Ellence®, Pharmorubicin®)
- Estramustine (Emcyt®)
- Etoposide (VePesid®, VP-16)
- Floxuridine (FUDR®, Fluorodeoxyuridine)
- Fludarabine
- fludarabine (Fludara®)
- Fluorouracil (Adrucil®, 5-FU)
- Gemcitabine (Gemzar®)
- Hydroxyurea (Hydrea®)
- Idarubicin (Idamycin®)
- Ifosfamide (IFEX®)
- Interferon Alpha (Intron-A®, Roferon-A®)
- Irinotecan (Camptosar®, CPT -11)
- Isotretinoin (Accutane®)
- L-Asparaginase (Elspar®)
- Lomustine (CCNU, CeeNU®)
- Mechlorethamine (Mustargen®, Nitrogen Mustard)
- Melphalan (Alkeran®, L-PAM)
- Methotrexate (MTX)
- Mitomycin (Mitomycin C, Mutamycin)
- Mitoxantrone (Novantrone®)
- Oxaliplatin (Eloxatin®)
- Paclitaxel (Taxol®)
- Plicamycin (Mithracin, Mithramycin)
- Prednisone (used as chemotherapy, doses > 20mg)
- Procarbazine (Mutalane®)
- Streptozocin (Zanosar®)
- Temozolomide (Temodar®)
- Teniposide (Vumon®)
- Thiotepa (Thioplex®)
- Topotecan (Hycamtin®)
- Trastuzumab (Herceptin®)
- Tretinoin (Vesanoid®, All-trans retinoic acid, ATRA)
- Trimotrexate
- Vinblastine (Velban®)
- Vincristine (Oncovin®)
- Vinorelbine (Navelbine®)

HORMONE THERAPIES

- Anastrozole (Arimidex®)
- Bicalutimide (Casodex®)
- Exemestane (Aromasin®)
- Flutamide (Eulexin®)
- Fulvestrant (Faslodex®)
- Goserelin (Zoladex®)
- Letrozole (Femara®)
- Leuprolide (Lupron®)
- Nilutamide (Nilandron®)
- Tamoxifen (Nolvadex®)
- Toremifene (Fareston®)

Other Medication Not Listed:

Other therapy not listed above:

4. Did you receive intrathecal chemotherapy (administered into your spinal fluid)?

- No Yes

4a. IF YES: What chemotherapies did you receive? (Check all that apply)

- Cytarabine (Cytosar-U®, Ara-C)
 Fluorouracil (Adrucil®, 5-fluorouracil, 5-FU)
 Methotrexate (Rheumatrex®, Trexall™, MTX)

Other therapy not listed above:

RADIATION THERAPY

5. Did you receive radiation therapy? No Yes

5a. IF YES: What type of treatment did you receive? (Check all that apply)

Radiation treatment for primary tumor site:

- | | |
|---|---|
| <input type="checkbox"/> Treatment for biliary cancer (radiation to gallbladder, pancreas, or ampulla of vader) | <input type="checkbox"/> Treatment for lymphoma (Radiation to chest/mediastinum/neck) |
| <input type="checkbox"/> Treatment for brain and spinal cord tumors | <input type="checkbox"/> Treatment for lymphoma (Radiation to groin/abdomen) |
| <input type="checkbox"/> Treatment for breast cancer | <input type="checkbox"/> Treatment for mesothelioma |
| <input type="checkbox"/> Treatment for colorectal cancer | <input type="checkbox"/> Treatment for prostate cancer |
| <input type="checkbox"/> Treatment for esophageal cancer | <input type="checkbox"/> Treatment for sarcomas (chest and chest Wall) |
| <input type="checkbox"/> Treatment for female reproductive tract (Radiation for endometrial, uterine, cervical, ovarian or vulvar/ vaginal cancers) | <input type="checkbox"/> Treatment for sarcomas (retroperitoneal and abdominal) |
| <input type="checkbox"/> Treatment for gastric (stomach) cancer | <input type="checkbox"/> Treatment for sarcomas of the extremity (arm/leg) |
| <input type="checkbox"/> Treatment for head/ neck cancers | <input type="checkbox"/> Treatment for testicular cancer |
| <input type="checkbox"/> Treatment for Hodgkin's disease ("Mantle Field") | <input type="checkbox"/> Treatment for Thymoma or Thymic Carcinoma |
| <input type="checkbox"/> Treatment for lung cancer | |

Treatment for metastatic cancer or total body irradiation:

- Radiation for metastasis to the bone
- Radiation for metastasis to the brain or spinal cord
- Radiation for metastasis to the lung
- Radiation for metastasis to the lymph nodes
- Radiation for metastasis to the skin
- Total Body Irradiation

Other radiation not listed above:

6. Did you receive radioiodine therapy (I-131)? No Yes

7. Have you been told you have a genetic abnormality or syndrome? No Yes