

SWEET - Follow up Questionnaire

Trial ID:

Initials:

Timepoint:

- 6month follow-up
 12month follow-up
 18month follow-up

Office use only

ABOUT THESE QUESTIONS

Thank you for taking part in the SWEET study. This questionnaire asks about you, your experiences and views of breast cancer and hormone therapy and how people with breast cancer use the health and care services available to them. Please try and complete all the questions in full, even if they seem similar or repetitive as this will help us to collect the most reliable information for the study. **If questionnaires are not fully completed, it will affect the success of the study - that means it is less likely that the study will be able to help other women with breast cancer in the future.**

Once you have completed this questionnaire, please return it to your local research team, or return it directly to the SWEET trial office using the pre-paid envelope provided.

SWEET Trial Office
Warwick Clinical Trials Unit,
Warwick Medical School
University of Warwick
Coventry, CV4 7AL

There are no right or wrong answers - we just want to hear about your own views and experiences. Everything you tell us is **completely confidential** – we won't share your questionnaire with any of the doctors or nurses involved in your care, or anyone outside the research team. The questionnaire should take approximately **25-40 minutes to complete**. You may find it easier not to complete it all in one go.

If you have any questions or difficulty completing the questionnaire, please contact your local research team.

Throughout the questionnaire you will find references to **hormone therapy**. This is sometimes called endocrine therapy and refers to any of the following medications:

- tamoxifen
- anastrozole (Arimidex®)
- letrozole (Femara®)
- exemestane (Aromasin®)

Please answer the questions with regards to the hormone therapy you have been prescribed, **even if you are not currently taking it.**

SECTION A: About your hormone therapy

This section is about your experiences of, and what you think about, taking hormone therapy.

A1. Please enter today's date:

A2. Please rate the information you have received or obtained about each of the following aspects of your hormone therapy (e.g. tamoxifen, letrozole, anastrozole, exemestane).

	Too much	About right	Too little	None received	None needed
What your hormone therapy is for	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What it does	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How it works	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How long you will need to be on your hormone therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How to take your hormone therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How to get a further supply	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whether the hormone therapy has any unwanted effects (side-effects)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What are the risks of you getting side-effects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What you should do if you experience any unwanted side-effects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whether hormone therapy interferes with other medicines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whether hormone therapy will affect your sex life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What you should do if you forget to take a dose of hormone therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A2a. How did you receive or obtain information about hormone therapy? (please tick all that apply)

- Breast cancer doctor
- Breast cancer nurse
- GP
- Attended workshop or course (please specify)
- Charity websites or information leaflets/booklets
- HT&Me Support Package
- Other (please specify)

A3. How frequently do you take your hormone therapy?

Daily	<input type="checkbox"/>	Most days	<input type="checkbox"/>	At least 3 times a week	<input type="checkbox"/>	At least once a week	<input type="checkbox"/>	Less than once a week	<input type="checkbox"/>	Not at all	<input type="checkbox"/>
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A4. How many of your hormone therapy tablets have you taken *in the past 7 days*?

A5a. Since you started the SWEET study, have you switched types of hormone therapy (e.g. changing from anastrozole to letrozole)?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
		<i>If No, please go to question A6a.</i>	

A5b. If yes, what type of oral hormone therapy are you currently being prescribed?

tamoxifen	<input type="checkbox"/>	anastrozole	<input type="checkbox"/>	letrozole	<input type="checkbox"/>	exemestane	<input type="checkbox"/>	other (please specify)	<input type="checkbox"/>
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A5c. If you have switched treatments, approximately when did you switch?

A5d. Why did you switch treatments?

A6a. Since you started the SWEET study, have you stopped taking your hormone therapy completely?

Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
		<i>If No, please go to question A7</i>	

A6b. If yes, approximately when did you stop taking it?

A6c. If yes, why did you stop taking it?

If you have stopped taking your hormone therapy, please answer the remaining questions thinking about how you felt when you were *last taking hormone therapy*.

A7. We would like to ask you about your personal views about your hormone therapy. These are statements other people have made about their hormone therapy. Please show how much you agree or disagree with them by ticking the appropriate box.

There are no right or wrong answers, we are interested in your personal views.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Having to take hormone therapy worries me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I sometimes worry about the long-term effects of taking hormone therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hormone therapy is a mystery to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking hormone therapy disrupts my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I sometimes worry about having to take hormone therapy over a long period of time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My health at present depends on me taking hormone therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking hormone therapy makes me feel I am taking positive steps to remain well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Without taking hormone therapy I would be more likely to develop breast cancer again	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My health in the future will depend on me taking hormone therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hormone therapy protects me from becoming ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have been supported to make the right decision for me about taking hormone therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
All my questions about hormone therapy have been answered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The pros and cons of hormone therapy are clear to me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have received all the support I need around taking hormone therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am fully informed about my breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have many unanswered questions about hormone therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am clear about the benefits and risks of hormone therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A8. Many people find a way of taking their hormone therapy tablets which suits them. This may differ from the instructions on the label or from what their doctor had said. We would like to ask you a few questions about how you use your hormone therapy.

Here are some ways in which people have said they use their hormone therapy. For each statement, please tick the box which best applies to you in the past month.

	Always	Often	Some-times	Rarely	Never
I forget to take my hormone therapy tablets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I alter the dosage of my hormone therapy tablets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I stop taking hormone therapy for a while	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I decide to miss out a dose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I take less hormone therapy tablets than instructed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

A9. Please indicate the extent to which you agree or disagree with each of the following statements.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
I intend to take my hormone therapy every day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have a plan regarding when to take my hormone therapy (e.g. morning)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have a plan for how to take my hormone therapy when my routine changes (e.g. holidays)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am confident that I can take my hormone therapy every day for as long as has been prescribed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION B: How you feel

This section is about how you feel, and any side-effects of your breast cancer and its treatment.

B1. Below is a list of statements that other women with breast cancer have said are important. Please tick one box per line to indicate your response as it applies to the past 7 days.

	Not at all	A little bit	Some-what	Quite a bit	Very much
I have a lack of energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Because of my physical condition, I have trouble meeting the needs of my family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am bothered by side effects of treatment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am forced to spend time in bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel close to my friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get emotional support from my family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get support from my friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My family has accepted my illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am satisfied with family communication about my illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel close to my partner (or the person who is my main support)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am satisfied with my sex life <i>(please answer this question regardless of your current level of sexual activity. If you prefer not to answer, please skip to the next question.)</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Please continue answering the questions below:

I feel sad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am satisfied with how I am coping with my illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am losing hope in the fight against my illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I feel nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I worry about dying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Not at all	A little bit	Some-what	Quite a bit	Very much
I worry that my condition will get worse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am able to work (including work at home)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My work (including work at home) is fulfilling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am able to enjoy life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have accepted my illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am sleeping well	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am enjoying the things I usually do for fun	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am content with the quality of my life right now	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

B2. Have you been bothered by any of these symptoms in the past four weeks? Please tick one box per line to indicate how bothered you have been in the *past 4 weeks*.

	Not at all	Slightly	Moderately	Quite a bit	Extremely
Hot flushes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Muscle stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
General aches and pains	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vaginal dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain with intercourse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Forgetfulness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty concentrating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easily distracted	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Unhappy with appearance of my body	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genital itching/irritation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritability or mood changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

B3. Please rate your confidence in your ability to cope with the following symptoms on a scale from 1 (not confident) to 10 (very confident). Please circle one number on each row. If you haven't had a specific symptom, please tick the not applicable (N/A) option.

	N/A	Not at all confident										Totally confident
Hot flushes	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10	
Night sweats	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10	
Joint aches and pains	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10	
Sexual problems	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10	
Fatigue	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10	
Sleep problems	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10	
Changes in mood	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10	
Memory problems	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10	
Weight changes	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10	
Emotional problems	<input type="checkbox"/>	1	2	3	4	5	6	7	8	9	10	

B4. Please rate your confidence in your ability to do the following things on a scale from 1 (not at all confident) to 10 (totally confident). Please circle one number on each row.

	Not at all confident										Totally confident
Get support from friends and family if you have any problems with your hormone therapy?	1	2	3	4	5	6	7	8	9	10	
Get support from health professionals if you have any problems with your hormone therapy?	1	2	3	4	5	6	7	8	9	10	

SECTION C: About your breast cancer

This section asks about your beliefs about your breast cancer and hormone therapy.

C1. We are interested in views you hold currently about your breast cancer and hormone therapy. Please indicate how much you agree or disagree with the following statements about breast cancer by ticking the appropriate box.

	Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree
Hormone therapy has major consequences on my life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I can't function normally whilst taking hormone therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking hormone therapy has had an impact on those around me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My work / social life has been affected by taking hormone therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There's a good chance my cancer will come back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I expect to have a recurrence of cancer in the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am extremely likely to have a recurrence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
The chance of my cancer coming back is low	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There are things I can do to stop the cancer coming back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
What I do has an influence on whether my cancer comes back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There is nothing I can do to help my risk of recurrence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My actions will have no effect on the risk of cancer coming back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hormone therapy can reduce my risk of recurrence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There is very little that can be done to stop the cancer coming back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking hormone therapy will help stop the cancer coming back	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
There is nothing that can help my risk of recurrence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

C2. We are interested in your views on possible causes of breast cancer coming back (recurrence). For each of the factors below please indicate the extent to which you agree or disagree that it may influence your risk of recurrence. There are no right or wrong answers.

	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
Stress or worry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Runs in the family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
A germ or virus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diet or eating habits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chance or bad luck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pollution in the environment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My own behaviour	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family problems or worries	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
My emotional state (e.g., feeling down, lonely, anxious, empty)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ageing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hormonal influence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
God's will	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION D: About your lifestyle and your general health

This section asks about your current lifestyle, including exercise and alcohol consumption.

D1. How tall are you? Please complete then tick one box to tell us the unit of measurement.

	in cm/m <input type="checkbox"/>	or ft/inches <input type="checkbox"/>
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D2. How much do you weigh? Please complete then tick one box to tell us the unit of measurement.

	in kg <input type="checkbox"/>	or stone/lbs <input type="checkbox"/>
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D3. The following questions are about how active you are. During a typical 7-day period (a week), how many times on average do you do the following kinds of exercise for more than 15 minutes during your free time.

	Times per week
a. Strenuous exercise (heart beats rapidly) (e.g., running or jogging, team sports, squash, fast swimming, riding a bike fast or on hills)	<input type="text"/>
b. Moderate exercise (not exhausting) (e.g., fast walking or hiking, water aerobics, Zumba, tennis, easy bicycling, badminton, easy swimming, popular and folk dancing)	<input type="text"/>
c. Mild/light exercise (minimal effort) (e.g., yoga, bowling, golf, easy walking)	<input type="text"/>


These questions are about your alcohol intake.

1 unit is typically:
 Half-pint of regular beer, lager or cider; 1 small glass of low ABV wine (9%); 1 single measure of spirits (25ml)

UNIT GUIDE



The following drinks have more than one unit:
 A pint of regular beer, lager or cider, a pint of strong /premium beer, lager or cider, 440ml regular can cider/lager, 440ml "super" lager, 250ml glass of wine (12%)



D4. How often do you have a drink containing alcohol?

Never	<input type="checkbox"/>
Monthly or less	<input type="checkbox"/>
2-4 times a month	<input type="checkbox"/>
2-3 times a week	<input type="checkbox"/>
4 or more times a week	<input type="checkbox"/>

D5. How many units of alcohol do you drink on a typical day when you are drinking?

Not applicable - I don't drink alcohol	<input type="checkbox"/>
1 or 2	<input type="checkbox"/>
3 or 4	<input type="checkbox"/>
5 or 6	<input type="checkbox"/>
7, 8 or 9	<input type="checkbox"/>
10 or more	<input type="checkbox"/>

D6. How often have you had 6 or more units on a single occasion in the last year?

Never	<input type="checkbox"/>
Less than monthly	<input type="checkbox"/>
Monthly	<input type="checkbox"/>
Weekly	<input type="checkbox"/>
Daily or almost daily	<input type="checkbox"/>

D7. These questions are about smoking.

	Yes	No
a. Have you ever smoked cigarettes regularly – that is at least one cigarette per day for 6 months or more? (not including e-cigarettes)	<input type="checkbox"/>	<input type="checkbox"/>
b. Do you smoke cigarettes now? (not including e-cigarettes)	<input type="checkbox"/>	<input type="checkbox"/>

D8. Under each heading, please tick the ONE box that best describes your health TODAY

a. MOBILITY

I have no problems in walking about	<input type="checkbox"/>
I have slight problems in walking about	<input type="checkbox"/>
I have moderate problems in walking about	<input type="checkbox"/>
I have severe problems in walking about	<input type="checkbox"/>
I am unable to walk about	<input type="checkbox"/>

b. SELF-CARE

I have no problems washing or dressing myself	<input type="checkbox"/>
I have slight problems washing or dressing myself	<input type="checkbox"/>
I have moderate problems washing or dressing myself	<input type="checkbox"/>
I have severe problems washing or dressing myself	<input type="checkbox"/>
I am unable to wash or dress myself	<input type="checkbox"/>

c. USUAL ACTIVITIES (e.g. work, study, housework, family or leisure activities)

I have no problems doing my usual activities	<input type="checkbox"/>
I have slight problems doing my usual activities	<input type="checkbox"/>
I have moderate problems doing my usual activities	<input type="checkbox"/>
I have severe problems doing my usual activities	<input type="checkbox"/>
I am unable to do my usual activities	<input type="checkbox"/>

d. PAIN / DISCOMFORT

I have no pain or discomfort	<input type="checkbox"/>
I have slight pain or discomfort	<input type="checkbox"/>
I have moderate pain or discomfort	<input type="checkbox"/>
I have severe pain or discomfort	<input type="checkbox"/>
I have extreme pain or discomfort	<input type="checkbox"/>

e. ANXIETY / DEPRESSION

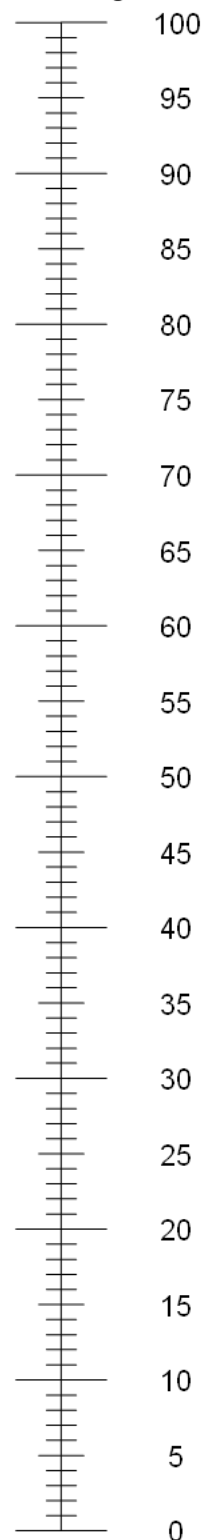
I am not anxious or depressed	<input type="checkbox"/>
I am slightly anxious or depressed	<input type="checkbox"/>
I am moderately anxious or depressed	<input type="checkbox"/>
I am severely anxious or depressed	<input type="checkbox"/>
I am extremely anxious or depressed	<input type="checkbox"/>

D9. We would like to know how good or bad your health is today. The scale is numbered from 0 to 100, 100 means the best health you can imagine and 0 means the worst health you can imagine.

- Please mark an X on the scale to indicate how your health is **TODAY**.
- Now, write the number you marked on the scale in the box below.

YOUR HEALTH TODAY =

The best health
you can imagine



The worst health
you can imagine

IF YOU DID NOT RECEIVE ACCESS TO THE HT&Me SUPPORT PACKAGE AS PART OF THE STUDY, PLEASE SKIP TO SECTION F.

If you did receive access, please continue to answer the questions below (SECTION E).

SECTION E: HT&Me support package feedback

This part of the questionnaire pack asks you some questions about your thoughts and experiences with the HT&Me support package. Some of these questions refer to the overall HT&Me support package (that is, the package as a whole), and others refer to some of the specific features within it (e.g., nurse/practitioner appointments, website and email/text contacts).

E1. Please rate how helpful you found specific parts of the HT&Me support package, by ticking the box that applies to you. If you have not looked at or used parts of the HT&Me support package, or if you do not think the question is relevant to you, please select the 'Not Applicable' option (N/A):

	Not Applicable (N/A)	Very unhelpful	Somewhat unhelpful	Neither helpful nor unhelpful	Somewhat helpful	Very helpful
a. Initial appointment with the HT&Me study nurse / practitioner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Follow-up appointment with the HT&Me study nurse / practitioner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. HT&Me website	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Receiving text / email messages to remind me to take my hormone therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Receiving text / email messages to remind me to collect my prescription	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Receiving text/email messages to remind me about the HT&Me website	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Receiving text/email messages to remind me why taking hormone therapy is important	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Overall HT&Me support package (e.g., the nurse/practitioner appointments, the website and text/email messages)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The following questions refer to sections within the HT&Me website:

i. 'Taking Hormone Therapy' section	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Animation video (cartoon film) about hormone therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. 'Dealing with Side Effects' section	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. 'Healthy living, Healthy mind' section	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. 'Help and Support' section	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. 'My Hormone Therapy Diary' section	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E1 Continued:

	Not Applicable (N/A)	Very unhelpful	Somewhat unhelpful	Neither helpful nor unhelpful	Somewhat helpful	Very helpful
o. 'My Goals and Plans' tool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. 'My Personal Support' tool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E2. Please tell us whether you agree or disagree with the following statements:

The overall HT&Me support package:	Not Applicable (N/A)	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree
a. Increased my knowledge about hormone therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Increased my understanding of why taking hormone therapy is important	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Motivated me to keep taking my hormone therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Helped me talk to my doctor about hormone therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Helped me with any emotional concerns about hormone therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Made me feel more anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Helped me to manage any side effects	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Was relevant for me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Was overwhelming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Was trustworthy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Was an unwelcome reminder of cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Was easy to understand	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Was easy to use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Took too much effort	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

E3. We would like to ask you about the timing of receiving the HT&Me support package. In relation to when you first started taking your hormone therapy, do you feel that the timing of receiving the HT&Me support package was:

Too early	<input type="checkbox"/>	Just about right	<input type="checkbox"/>	Too late	<input type="checkbox"/>
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SECTION F: Health care use

We would like to know whether you have used health and care services over the past 6 months for anything that is (in your opinion) related to your breast cancer or any related side-effects and complications. **Please give your best guess if you don't know the exact number.** Please answer every question if you can, even if the answer is 0.

Section F1: Contact with NHS primary and community health care and charity providers

1. **Have you had any contact with health professionals in an NHS primary health care or *community*-based setting or *charity* services (i.e. outside the hospital setting, e.g. GP, counsellor, practice or district nurse) for anything which, in your opinion, was related to your breast cancer or any related side-effects and complications during the past 6 months?**

Yes No

If you ticked 'yes', please complete the table below:

If you ticked 'no', please go to question 2 in Section F2

Please don't include in this table any contacts that were in a hospital or that you paid for privately, we will ask you about these later.

Type of health care provider	Have you used the service during the past 6 months?	Total number of face-to-face contacts (in person, video conference, or 'online') during the past 6 months	Total number of contacts by telephone or email during the past 6 months
GP	Yes <input type="checkbox"/> No <input type="checkbox"/>		
GP practice nurse	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Macmillan nurse (or other charitable care provider)	Yes <input type="checkbox"/> No <input type="checkbox"/>		
District nurse or community health team	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Paid carer (to help with healthcare, personal or household tasks in your home)	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Counselling, or mental health support	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Community Pharmacist	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Family or patient support or information, or courses/workshops provided by cancer charities e.g. Breast Cancer Now, Maggie's Centre	Yes <input type="checkbox"/> No <input type="checkbox"/>		
NHS direct (111)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Not applicable	
Other (please specify):	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Other (please specify):	Yes <input type="checkbox"/> No <input type="checkbox"/>		

Section F2: Contact with NHS hospital-based services

2. Have you used any NHS hospital-based services during the **past 6 months** (e.g. outpatient hospital visits, inpatient stay, A&E) for anything which in your opinion was related to your breast cancer or any related side-effects and complications?

Yes No

If you ticked 'yes', please complete the questions below.

If you responded 'no', please go to Section F3.

a) Type of hospital service	Have you used this service during the past 6 months for your breast cancer?	Total number of <i>face-to-face</i> (in person or video-conference/ online) contacts during the past 6 months	Total number of contacts by <i>telephone or email</i> during the past 6 months
Hospital outpatient clinic: cancer/oncology (eg follow-up appointment with breast cancer team)	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Hospital physiotherapy	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Hospital counselling	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Hospital dietitian	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Hospital occupational therapy	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Hospital lymphoedema clinic	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Other hospital outpatient appointment	Yes <input type="checkbox"/> No <input type="checkbox"/>		
If other, please state:			

b) Were any procedures or scans undertaken at a hospital outpatient clinic? (Please include everything you have had in the past 6 months excluding those done during an inpatient stay)

	Number of times you have had this scan/procedure in the last 6 months
Mammogram	
Ultrasound	
CT scan	
MRI scan	
X-ray	
Needle biopsy	
Needle aspiration	
Bone scan	
Radiotherapy	
Chemotherapy	
Other	
(please specify)	

c) **Have you had any hospital day case visits in the last 6 months for anything which in your opinion was related to your breast cancer or any related side-effects and complications?** (e.g. for cancer, infection or mental health) A day case is an admission to hospital where you are given a hospital bed but do not stay overnight.

Yes No

If yes:

- i) How many day case visits? _____
- ii) Why did you have the day case(s)? _____
- iii) If you had any procedures or scans, please write them here _____

d) **Have you been to the hospital A&E department in the last 6 months for anything which in your opinion was related to your breast cancer or any related side-effects and complications?**

Yes No

If yes:

- i. How many times did you visit A&E? _____

e) **Have you stayed overnight in hospital in the last 6 months for anything which in your opinion was related to your breast cancer or any related side-effects and complications?** (e.g. for cancer, infection or mental health)

Yes No

If yes:

- i) How many times did you stay overnight in hospital? _____
- ii) For each hospital inpatient stay related to your breast cancer, please fill in the following information:

Stay	Number of nights spent in hospital	Why were you admitted to hospital? Please select the main reason using numbers 1-8 below	If other, what?	If you had an operation, what type? (free text)	If you were in intensive care, please tell us how many days
Stay 1					
Stay 2					
Stay 3					
Stay 4					
Stay 5					
Stay 6					
Stay 7					
Stay 8					

- 1 Cancer
- 2 Infection
- 3 DVT or clot
- 4 Breast surgery

- 5 Problem with a breast implant
- 6 Fracture/broken bone
- 7 Mental health
- 8 Other (please state)

3. Have you taken any **prescribed** medications **over the past 6 months** for anything which in your opinion was related to your breast cancer or any related side-effects and complications? You should tick “no” if the only medication you are prescribed is your hormone treatment. Please include ongoing medications as well as new prescriptions.

Yes No

If you responded ‘no’ please go to section F4.

If you responded ‘yes’, please complete the following table:

Please only include medication prescribed by a doctor or nurse in this table: if you bought any medication over the counter please include this in section F4.

Prescribed Medication	Have you used this medication during the past 6 months?	Date started dd/mm/yy	Date completed dd/mm/yy	Please tick if you are still using this medication
Bisphosphonates (medication for osteoporosis eg alendronic acid, ibandronic acid, risedronate, zoledronic acid)	Yes <input type="checkbox"/> No <input type="checkbox"/>			<input type="checkbox"/>
Anti-depressants (eg fluoxetine, sertraline, citalopram)	Yes <input type="checkbox"/> No <input type="checkbox"/>			<input type="checkbox"/>
Calcium supplements (for osteoporosis)	Yes <input type="checkbox"/> No <input type="checkbox"/>			<input type="checkbox"/>
Vitamin D supplements (for osteoporosis)	Yes <input type="checkbox"/> No <input type="checkbox"/>			<input type="checkbox"/>
Medications for hot flushes (eg gabapentin, venlafaxine, citalopram).	Yes <input type="checkbox"/> No <input type="checkbox"/>			<input type="checkbox"/>
Progesterone-based medications (e.g. Megace)	Yes <input type="checkbox"/> No <input type="checkbox"/>			<input type="checkbox"/>
Chemotherapy (either tablets or injections) <i>Please state drugs if known:</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>			<input type="checkbox"/>
Vaginal gels and moisturisers	Yes <input type="checkbox"/> No <input type="checkbox"/>			<input type="checkbox"/>
Vaginal oestrogen	Yes <input type="checkbox"/> No <input type="checkbox"/>			<input type="checkbox"/>
Homeopathic remedies	Yes <input type="checkbox"/> No <input type="checkbox"/>			<input type="checkbox"/>
Other: <i>Please specify:</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>			<input type="checkbox"/>
Other: <i>Please specify:</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>			<input type="checkbox"/>
Other: <i>Please specify:</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>			<input type="checkbox"/>

4. **Over the past 6 months**, have you or your family/carers incurred any personal costs (e.g. over the counter medications, travel and childcare expenses, private health care) which in your opinion is related to your breast cancer or any related side-effects and complications? We are asking this as we would like to find out about the impact of your breast cancer and treatment on your personal finances.

Yes No

If you ticked 'yes', please complete the following table:

If you ticked 'no' please go to question 5 in section F5.

		Approximate total cost to you or your family/friends
Have you spent any money on travelling to medical appointments over the past 6 months for your breast cancer or any related side-effects and complications ? (medical appointments may include visits to your GP surgery, hospital or any other health care setting e.g. GP walk-in centres). Travel costs may include bus fares, train fares, fuel costs and parking charges.	Yes <input type="checkbox"/> No <input type="checkbox"/>	£ _____
Have you paid for private practitioners over the past 6 months for your breast cancer or any related side-effects and complications ? (such as private hospital care, acupuncturists, physiotherapists, counselling or lymphoedema services).	Yes <input type="checkbox"/> No <input type="checkbox"/>	£ _____
Have you had to pay for child care over the past 6 months as a result of your breast cancer or any related side-effects and complications ?	Yes <input type="checkbox"/> No <input type="checkbox"/>	£ _____
Have you paid for, or had to buy, anything else over the past 6 months for your breast cancer or any related side-effects and complications ? If yes, please tell us what this was:	Yes <input type="checkbox"/> No <input type="checkbox"/>	£ _____

Section F5: Time off work and usual activities

5. We would like to find out the impact on your work and usual activities from your breast cancer and treatment over the over the past 6 months.

Which of these best describes your current employment status?

(If you are employed or self-employed but are currently on sick leave or working reduced hours due DA illness, please select the option that best describes your usual work status)

In paid work (including self-employed) full-time or part-time	<input type="checkbox"/>	Unemployed	<input type="checkbox"/>
Homemaker	<input type="checkbox"/>	Retired	<input type="checkbox"/>
Unable to work because of long-term disability or ill health	<input type="checkbox"/>	In full-time education, training or work experience	<input type="checkbox"/>
Other (<i>please tell us more</i>)			

Time off work and usual activities		Please complete as Hours or Days	
In the past 6 months have you had any time off paid work as a result of your breast cancer or related conditions or problems caused by your cancer (This may include time off because you were feeling ill, were attending medical appointments or in hospital etc).	Yes <input type="checkbox"/> No <input type="checkbox"/>	Approximate number of hours OR days off paid work:	_____ hours
			_____ days
In the past 6 months, have you had to change your other usual activities (excluding any changes to your paid work) because of your breast cancer, or related conditions or problems caused by your cancer. (This may include changes to your usual activities because were feeling ill, attending medical appointments or in hospital etc). <i>Usual activities</i> may include social arrangements, housework, shopping, child care, study, exercise, or other hobbies.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Approximate number of hours OR days off other usual activities:	_____ hours
			_____ days

5b) Have you received help or support from family or friends over the past 6 months, which in your opinion was related to your breast cancer or any related side-effects and complications?

Yes No

If yes, approximately how much time have they spent helping you over the past 6 months?	_____ hours
Did they have to take any time off paid work to help or support you?	Yes <input type="checkbox"/> No <input type="checkbox"/>
Approximately how much time in total did they take off paid work over the past 6 months?	_____ hours

Thank you for completing this questionnaire.

If you have questions about your breast cancer care, please contact your clinical team. If you have questions about general health, you can contact your GP. If you would like more information, advice or support about living with breast cancer and hormone therapy in general you could contact the following charities:

Breast Cancer Now: 0808 800 6000 or breastcancernow.org
Macmillan Cancer Support: 0808 808 0000 or macmillan.org.uk
Maggie's cancer support centres: <https://www.maggies.org/>

Should you be experiencing any difficult emotions or feelings and wish to speak to someone, please contact Mind for advice (website: <https://www.mind.org.uk/>).

Thank you.