Endometrial Cancer And Weight Questionnaire

This is a voluntary research study survey for women with uterine cancer. This survey is for research purposes only and your participation or desire not to participate in no way affects your healthcare. All answers are confidential. We are hoping to learn more from you about how to better help women lose weight. Thank you for your time!

The survey has two parts and you may answer either only the first part or both:

Section 1: Answer the following questions.

Section 2: If you are interested in more information or in possible participation in a weight loss program for women, please fill out your contact information on the last page. A study coordinator will then contact you to answer further questions and to discuss the study in detail.

Please contact the study team if you have any problems or questions: ****contact information goes here****

Thank you for taking time to answer these questions. Your answers will help us understand more about weight and how it relates to endometrial cancer. Please provide an answer to each of the following questions.

SECTION 1: Survey Questions

1. Which best describes your ethnic background:
   - ☐ White
   - ☐ African American
   - ☐ Asian
   - ☐ Other
   (Please circle all that are appropriate.)

2. If other race, please specify:

3. What is your annual household income from all sources?
   - ☐ Less than $25,000
   - ☐ $25,000 to less than $50,000
   - ☐ $50,000 to less than $75,000
   - ☐ $75,000 or more
   - ☐ Not sure

4. Did you have radiation or chemotherapy for your uterine cancer?
   - ☐ Yes
   - ☐ No

5. If yes, when was your last treatment?

6. As far as you know, does excess weight affect a woman's risk of getting endometrial (lining of the uterus) cancer?
   - ☐ Yes
   - ☐ No
   - ☐ I don't know
6. As far as you know, does excess weight affect how long you will live after getting endometrial cancer?

- Yes
- No
- I don't know
7. Have you been diagnosed with any of the following health conditions?

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>I don't know</th>
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</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>High cholesterol</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>High blood pressure</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>Overweight or obesity</td>
<td>○</td>
<td>○</td>
<td>○</td>
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<tr>
<td>Depression</td>
<td>○</td>
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<tr>
<td>Arthritis</td>
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8. In the past 6 months, have you thought about trying to lose or stop gaining weight?

- Yes
- No
- I don't know

9. With whom do you feel comfortable discussing your weight?

- Family
- Friend
- Doctor
- Nurse
- I don't discuss my weight with anyone
- Other
(Please circle all that are appropriate.)

If other, please specify:

10. How important do you feel it is to discuss your weight with your doctor?

- Not at all important
- Only a little important
- Important
- Very important

If other motivation, please describe:

11. Today, if you want to lose weight, what motivates you?

- I am not interested in losing weight.
- Long-term health risks of being overweight
- I have been diagnosed with a weight-related cancer
- My family
- I want to feel better
- To improve my physical appearance
- To improve my mental health
- Other
(Please circle all that are appropriate.)

If other barrier, please describe:

12. What do you see as barriers to weight loss?

- I am not motivated to lose weight.
- I do not have enough time.
- Family/support system is not interested.
- No transportation to programs that might work.
- Not enough money to join a program.
- Not enough money to afford healthy food.
- I do not have access to healthy food choices.
- Other
(Please circle all that are appropriate.)

If other barrier, please describe:

13. How comfortable do you think your health care providers are discussing weight with you?

- Not at all comfortable
- Somewhat uncomfortable
- Neutral
- Somewhat comfortable
- Very comfortable
14. With how many people do you live?

- 0
- 1
- 2
- 3
- 4 or more

If 1 or more, what are the ages of the people with whom you live?

Age of person 1: __________________________
Age of person 2: __________________________
Age of person 3: __________________________
Age of person 4: __________________________
Age of person 5: __________________________
Age of person 6: __________________________
Age of person 7: __________________________
Age of person 8: __________________________
Age of person 9: __________________________
Age of person 10: __________________________

15. I have a strong support system to help with a behavioral change such as weight loss

- Strongly agree
- Slightly agree
- Neutral
- Slightly disagree
- Strongly disagree

16. What is the average number of hours you spend sitting or lying down (sedentary) each day?

- More than 6 hours
- 6 hours or less

17. How many weeks out of the year do you get at least 150 minutes of moderate-intensity, or 75 minutes of vigorous-intensity, activity each week (or a combination of these), preferably spread throughout the week?

- Most weeks
- Some weeks
- Never
- Other

If other, please provide comments: __________________________

18. Do you have any physical limitations to exercise such as walking?

- Knee pain
- Back pain
- Other joint pain
- Shortness of breath
- Heart problems
- Other

(if please check all that apply)

If other, please specify: __________________________

19. What is the average number of flights of stairs you climb daily?

- Every day
- Some days (> 3 days/week)
- Rarely (≤ 2 days/week)
- Never

20. How many days of the week do you eat at least 2 or more servings of fruits and/or vegetables?

- Every day
- Some days (> 3 days/week)
- Rarely (≤ 2 days/week)
- Never
21. The term "soft drink" refers to any beverage with added sugar or other sweetener, and includes soda, fruit punch, lemonade and other "ades," sweetened powdered drinks, and sports and energy drinks. How many of these drinks do you consume on most days?

- >5
- 3-4
- 1-2
- None
- Other

If other, please provide comments:
22. We are interested in hearing what has worked or has not worked for you in the past. Have you tried any of the following to lose weight?

<table>
<thead>
<tr>
<th></th>
<th>Weight loss medications</th>
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<tbody>
<tr>
<td>i.</td>
<td>If yes, # times:</td>
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<tr>
<td>ii.</td>
<td>If yes, how helpful was this for losing weight?</td>
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<td>iii.</td>
<td>If somewhat or very helpful, how long did it help you with weight loss?</td>
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<tr>
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<th>Changing diet</th>
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<td>i.</td>
<td>If yes, how helpful was this for losing weight?</td>
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<td>If somewhat or very helpful, how long did it help you with weight loss?</td>
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<th>Increasing exercise</th>
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<td>i.</td>
<td>If yes, how helpful was this for losing weight?</td>
<td></td>
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<tr>
<td>ii.</td>
<td>If somewhat or very helpful, how long did it help you with weight loss?</td>
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<th>Commercial weight loss programs</th>
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<td>i.</td>
<td>If yes, # times:</td>
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<th>Dietician/nutritionist</th>
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<td>i.</td>
<td>If yes, # times:</td>
<td></td>
</tr>
</tbody>
</table>

- a) Weight loss medications
  - Yes
  - No
  - I don't know

- b) Changing diet
  - Yes
  - No
  - I don't know

- c) Increasing exercise
  - Yes
  - No
  - I don't know

- d) Commercial weight loss programs

- e) Dietician/nutritionist
  - Yes
  - No
  - I don't know

- iii. If somewhat or very helpful, how long did it help you with weight loss? (Weight loss medications, Changing diet, Increasing exercise)
  - It helped for a long period of time (≥6 months)
  - It helped for a short period of time (<6 months)
  - It didn't help
i. If yes, # times:

ii. If yes, how helpful was this for losing weight?

iii. If somewhat or very helpful, how long did it help you with weight loss?

f) Physical therapist

i. If yes, # times:

ii. If yes, how helpful was this for losing weight?

iii. If somewhat or very helpful, how long did it help you with weight loss?

g) Psychologist

i. If yes, # times:

ii. If yes, how helpful was this for losing weight?

h) Meeting with bariatric (weight loss) surgeon

i) Bariatric (weight loss) surgery

i. If yes, what procedure did you have?

What was the date of the surgery?

ii. If yes, how helpful was this for losing weight?

iii. If somewhat or very helpful, how long did it help you with weight loss?

23. If your doctor suggested you might be a candidate for bariatric (weight loss) surgery, would you be interested?

If no, any specific reason why not?
24. I would be interested in participating in a formal weight loss program:  
   ☐ Yes  ☐ No

25. Text messaging is part of my daily life.  
   ☐ Yes  ☐ No

26. Daily text messaging about my weight would provide helpful motivation for weight management.  
   ☐ Yes, definitely  ☐ Maybe, I'm interested  ☐ Maybe, I doubt it  ☐ Not at all  ☐ I don't know

27. May we contact you for further information to participate in a weight loss program?  
   ☐ Yes  ☐ No

If yes, please provide your best contact information on the following section.

28. Please provide us with any comments about the survey or your experiences with trying to lose weight here:

   ________________________________

SECTION 2: Interest in participation in weight loss trial

YES. I am interested in participating in a formal weight loss support program. My best contact information for you to reach me to give me more information about participation is:

Name: ________________________________

Telephone Number: ________________________________

This is my... (please pick one):  
   ☐ Home  ☐ Mobile  ☐ Work

Email Address (optional): ________________________________

THANKS FOR YOUR PARTICIPATION!