

Ovarian Cancer Survivorship Survey

OMB #: 0920-XXXX
Exp. Date: XX/XX/XXXX

Thank you for your interest in the Ovarian Cancer Survivorship Survey sponsored by the Centers for Disease Control and Prevention (CDC). The information you provide help guide CDC's future efforts on how to help women with ovarian, fallopian tube, and primary peritoneal cancer as they are diagnosed, receive treatment, and begin to recover.

Participation in the study is voluntary. You may choose not to answer any questions that you do not wish to answer. You can end your participation at any time. All information collected for this study will be kept confidential. If you are eligible to participate, you will receive a \$10 Amazon gift code after completion of the study survey.


Please enter your unique Personal Identification Number (PIN) in the field below and click "Submit Survey PIN" button below:




CDC estimates the average public reporting burden for this collection of information as 50 minutes per response, including the time for reviewing instructions, searching existing data/information sources, gathering and maintaining the data/information needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-XXXX).

If you experience technical issues, please call 1-###-###-#### or email xxxx@norc.org for assistance.


INTRO



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Ovarian
CANCER
Research Survey



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EXIT

This survey is specifically for women who have been diagnosed with ovarian cancer. In addition to ovarian cancer, this survey is also for women who have been diagnosed with cancer of the fallopian tubes, or cancer of the primary peritoneum. For simplicity, all three of these cancers will be referred to as ovarian cancer throughout the survey.

Some women who participate in this survey will be much closer to their diagnosis and still undergoing treatment, while others may have ended treatment several years ago. Several questions will ask you to think back to when you were first diagnosed with ovarian cancer, or when you were receiving treatment. If you are currently receiving treatment, please answer these questions to the best of your ability.


Your answers will help us better understand how to help women with ovarian, fallopian tube, and primary peritoneal cancer as they are diagnosed, receive treatment, and begin to recover. Please answer all of the following questions by choosing the option that best applies to you. There are no "right" or "wrong" answers. The information that you provide will remain strictly confidential.

Your opinions are very important to us, and we appreciate your help.


BACK **NEXT**

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SCREENER1



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EXIT

Are you at least 18 years old?

Yes

No

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SCREENER2



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EXIT

Have you ever been diagnosed with ovarian, fallopian tube, or primary peritoneal cancer?


Yes

No


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SCREENER3



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EXIT

Have you received any treatment for your ovarian cancer?


Yes

No


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INELIGIBLE



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EXIT

Thank you for your interest in this study. Unfortunately, you are not eligible to participate in the survey at this time. Thank you for your time.


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INFORMED CONSENT



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EXIT

NORC at the University of Chicago is conducting a survey sponsored by the Centers for Disease Control and Prevention. This survey is to learn about your experiences as an ovarian cancer survivor. By taking this survey, you will help us identify needs of ovarian cancer survivors in order to develop programs aimed at improving survivor health.

The survey will include questions related to your experiences, health, and well-being as an ovarian cancer survivor as well as general demographics and questions related to health and cancer in your family. The survey will take about 50 minutes to complete.

Taking the survey is your choice. Some questions may be sensitive to you. You may skip questions you do not want to answer and you can stop the survey at any time. Eligible participants will be mailed \$10 at the end of the survey.

Any information you provide will be maintained in a secure manner. No one will know how you answered the questions. Only project staff will have access to the study data. The data we collect from you will be combined with data from other participants.

If you have any questions about the survey, you can call the NORC IRB Administrator toll-free at: 866-309-0542.

I have read the above information. I consent voluntarily to be a participant in this study.

Yes
 No


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INTRO2/DIAG_AGE



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EXIT

The questions in this survey will only indicate ovarian cancer, but are relevant to all 3 cancer types (ovarian, fallopian tube, or primary peritoneal cancer). The following questions are about your ovarian cancer symptoms and diagnosis.


What was your age when you were first diagnosed with ovarian cancer?

Years Old


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DIAG_HOW



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EXIT


Which of the following best describes how you were first diagnosed with ovarian cancer?

- I was diagnosed as part of a routine exam, check-up, or screening test.
- I was diagnosed after seeking medical care to check on problems or symptoms I was having.
- Other, please specify:


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SYMPTOM_A THROUGH SYMPTOM_F



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EXIT


Did you experience any of the following symptoms that were not normal for you in the weeks or month(s) leading up to your ovarian cancer diagnosis?

	Yes	No
Vaginal bleeding or discharge from your vagina that was not normal for you	<input type="radio"/>	<input type="radio"/>
Pain or pressure in the pelvic or abdominal area (area between your stomach to between your hip bones)	<input type="radio"/>	<input type="radio"/>
Lower back pain	<input type="radio"/>	<input type="radio"/>
Bloating or stomach swelling	<input type="radio"/>	<input type="radio"/>
Feeling full quickly or difficulty eating	<input type="radio"/>	<input type="radio"/>
Change in bathroom habits, such as more frequent or urgent need to urinate and/or constipation	<input type="radio"/>	<input type="radio"/>


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DIAG_TIME



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EXIT


How much time passed from when you started experiencing symptoms or knew something was wrong, to when you received an ovarian cancer diagnosis?

- A week or less
- 2 weeks
- 3 weeks
- A month
- 2 months
- More than 2 months, but less than 6 months
- More than 6 months
- Didn't experience any symptoms


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STAGE



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EXIT


At what stage was your ovarian cancer diagnosed?

- Stage 1
- Stage 2
- Stage 3
- Stage 4
- Other, please specify:
- Don't know


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DR_WHICH



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EXIT


Which of the following doctors diagnosed your ovarian cancer?

- Oncologist or cancer doctor
- Gynecological oncologist (specialty oncologist)
- Surgeon
- Primary care or Internal medicine doctor
- Gynecologist
- ER doctor
- Gastroenterologist
- Other, please specify:
- Don't know


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CANC_OTH



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EXIT

Other than your ovarian cancer, have you ever been diagnosed with any other kind of cancer?


Yes

No


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CANC_TYPE/CANC_AGE



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EXIT


What type of cancer and how old were you when diagnosed?

	Cancer Type	Age
1	<input type="text"/>	<input type="text"/>
2	<input type="text"/>	<input type="text"/>
3	<input type="text"/>	<input type="text"/>
4	<input type="text"/>	<input type="text"/>

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INTRO3/SURGERY



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EXIT

The following questions are about any treatment you may have received for your ovarian cancer.

Did you receive surgery as part of your ovarian cancer treatment?

Yes

No


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DR_SURG



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EXIT

Which doctor performed your ovarian cancer surgery?

Oncologist

General Surgeon

Gynecologist

Gynecologic Oncologist


Other, please specify:

Don't know


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TRAVEL_SURG



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EXIT

Approximately how long did you travel one-way to the hospital or facility where you received surgery for your cancer?

- Less than 30 minutes
- Thirty minutes or more, but less than one hour
- One hour or more, but less than 2 hours
- Two or more hours


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TRTMNT_A THROUGH TRTMNT_F



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EXIT


Did you receive any of the following cancer treatments as part of your ovarian cancer treatment?

	Yes	No	Don't Know
Chemotherapy that was injected into a vein or through a port (also known as intravenous)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Chemotherapy that was injected into the abdominal cavity (also known as intraperitoneal)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Monoclonal antibody therapy - uses antibodies made in a laboratory from immune cells; given through an infusion	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bevacizumab - antibody therapy used with chemotherapy to treat ovarian cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Poly polymerase inhibitors, or PARP inhibitors - drugs that block DNA repair and may cause cancer cells to die. <i>Examples: Olaparib, Niraparib</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other, please specify:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>


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TRAVEL_CHEMO



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EXIT


How long did you travel one-way to the hospital or facility where you received chemotherapy for your cancer?

- Less than 30 minutes
- Thirty minutes or more, but less than one hour
- One hour or more, but less than 2 hours
- Two or more hours


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CLINICTRIAL



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EXIT

Clinical trials are research studies that involve people. They are designed to test the safety and effectiveness of new treatments and to compare new treatments with standard care. Often, patients in clinical trials are not told what treatment they received until the trial is over.

Were you offered or did you seek out participation in a clinical trial as part of your ovarian cancer treatment? *Only include clinical trials for drugs to treat cancer. Do not include trials for medications to treat cancer-related side effects, like nausea.*

- Yes
- No

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TRIAL_PART



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EXIT

Did you participate in a clinical trial as part of your cancer treatment?

Yes

No


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NO_PART



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EXIT

Were you ever denied participation or decided not to participate in a clinical trial?


Yes

No


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REASON



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EXIT

What was the main reason you did not enter the clinical trial?

- I did not meet eligibility criteria.
- I refused the treatment protocol.
- I wanted to be treated elsewhere or by a different doctor.
- I wanted to know exactly what treatment I was receiving.
- Other, please specify:

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RECENT



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EXIT


How long ago was your most recent treatment for ovarian cancer?

- Currently receiving treatment
- Less than 12 months ago
- At least a year ago, but less than 3 years ago
- At least 3 years ago, but less than 5 years ago
- At least 5 years ago, but less than 10 years ago
- More than 10 years


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TRTMT_CURR



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EXIT

What treatment(s) are you currently receiving?


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ER_EVER



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EXIT

While undergoing cancer treatment, did you ever have to go to the emergency room (ER)?


Yes

No


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EFFECTS_A THROUGH EFFECTS_E



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EXIT


Many cancer patients experience several different symptoms or side effects while undergoing treatment. These side effects can vary from mild to severe. Did you have any of the following experiences while undergoing cancer treatment?

	Yes	No
Had to interrupt or delay treatment	<input type="radio"/>	<input type="radio"/>
Had to stop or suspend treatment	<input type="radio"/>	<input type="radio"/>
Doctors prescribed medication to deal with side effects	<input type="radio"/>	<input type="radio"/>
Doctors changed treatment to deal with side effects	<input type="radio"/>	<input type="radio"/>
Refer you to specialists to help deal with side effects	<input type="radio"/>	<input type="radio"/>


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RECUR



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EXIT

Since you were first diagnosed with and treated for ovarian cancer, has a doctor ever told you that your ovarian cancer had come back, that is, that you had a cancer recurrence?

- Yes
- No
- Don't know

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RECUR_AGE



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EXIT

What was your age when your cancer came back, or recurred?

 Years Old

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METASTASIS



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EXIT


Since you were first diagnosed with and treated for ovarian cancer, has a doctor or other health professional told you that your ovarian cancer had spread to another part of your body, that is, that you had a metastasis?

Yes
 No


BACK **NEXT**

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META_AGE



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EXIT


What was your age when you were diagnosed with a metastasis?

Years Old


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REMISSION



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EXIT


To the best of your knowledge, are you now free of cancer or been told that your cancer is in remission?

Yes
 No
 Don't know


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INTRO4



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EXIT

People who have received treatment for cancer often report that they continue experiencing a variety of symptoms or problems after, or even long after, they have completed treatment. The following questions are about potential symptoms and side effects from your cancer treatment.


BACK **NEXT**

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TXSYMPTOM_A THROUGH TXSYMPTOM_E



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EXIT


Have you ever experienced any of the following symptoms since you received treatment for your cancer?

	Yes	No
Numbness, prickling or tingling in your hands or feet	<input type="radio"/>	<input type="radio"/>
Sharp, jabbing, throbbing, freezing or burning pain in your extremities	<input type="radio"/>	<input type="radio"/>
Extreme sensitivity to touch	<input type="radio"/>	<input type="radio"/>
Lack of coordination or falling	<input type="radio"/>	<input type="radio"/>
Muscle weakness in your arms and legs	<input type="radio"/>	<input type="radio"/>


BACK **NEXT**

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EXPBEFORE



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EXIT

Had you ever experienced any of these symptoms before your cancer diagnosis and treatment?


Yes

No


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INTERFERE



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EXIT

How much have these symptoms interfered with your everyday activities, like getting dressed, working, participating in hobbies, doing usual household activities, or sleeping?

Very much

Quite a bit


A little

Not at all


BACK **NEXT**

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TALK_SYMP



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EXIT

Have you talked to a doctor or other health professional about these symptoms?

Yes

No

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TREAT_A THROUGH TREAT_G



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EXIT


Have you used any of the following treatments to help you address your symptoms?

	Yes	No
Over the counter pain relievers (like Tylenol, Aspirin, or Advil)	<input type="radio"/>	<input type="radio"/>
Prescription pain relievers	<input type="radio"/>	<input type="radio"/>
Other prescription drugs or medication	<input type="radio"/>	<input type="radio"/>
Electric nerve stimulation	<input type="radio"/>	<input type="radio"/>
Physical or Occupational therapy	<input type="radio"/>	<input type="radio"/>
Alternative treatments like acupuncture or herbal supplements	<input type="radio"/>	<input type="radio"/>
other, please specify:	<input type="radio"/>	<input type="radio"/>


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NEUROP



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EXIT


Since you received treatment for your cancer, has a doctor or any other health care provider told you that you have neuropathy? *Neuropathy is pain numbness or discomfort caused by damage to the nerves that brings signals to and from the brain and spinal cord to other parts of the body, such as the hands and feet. Some women develop neuropathy after receiving treatment for cancer.*

- Yes
- No
- Don't know
- Diagnosed before I had cancer


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SINCE_A THROUGH SINCE_J



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EXIT


Have you experienced any of the following since you received treatment for your cancer?

	Yes	No
Felt like you had to read something several times to understand it.	<input type="radio"/>	<input type="radio"/>
Felt like your thinking was slow.	<input type="radio"/>	<input type="radio"/>
Felt like you had to work really hard to pay attention or you would make a mistake.	<input type="radio"/>	<input type="radio"/>
Had difficulty concentrating	<input type="radio"/>	<input type="radio"/>
Had a hard time remembering things	<input type="radio"/>	<input type="radio"/>
Had a hard time reading and following complex instructions (e.g. directions for a new medication)	<input type="radio"/>	<input type="radio"/>
Had difficulty planning for and keeping appointments that are not part of your weekly routine (e.g. a therapy or doctor appointment, or a social gathering with friends and family)	<input type="radio"/>	<input type="radio"/>
Had trouble managing your time to do most of your daily activities	<input type="radio"/>	<input type="radio"/>
Had difficulty learning new tasks or instructions	<input type="radio"/>	<input type="radio"/>
Had trouble recalling the name of an object when talking to someone	<input type="radio"/>	<input type="radio"/>


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BEFORE



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EXIT


Had you experienced any of these symptoms before your cancer diagnosis and treatment?

- Yes
- No


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ACTIVITIES



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EXIT


How much have these symptoms interfered with your everyday activities, like doing your job, reading a book, participating in hobbies, or doing usual household activities?

- Very much
- Quite a bit
- A little
- Not at all


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SYMPTALK



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EXIT

Have you talked to a doctor or other health professional about these symptoms?


Yes

No


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COGNITIVE



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EXIT

Since you received treatment for your cancer, has a doctor or any other health care provider told you that you had chemo-brain, chemo-fog, or were suffering from cognitive issues due to chemotherapy?


Yes

No


BACK **NEXT**

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WGT_CHG



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EXIT

Did your weight change while you were undergoing cancer treatment?

- Yes, lost weight
- Yes, gained weight
- No, weight was more or less the same

BACK **NEXT**

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Next

WGT_REC



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EXIT


Since being diagnosed with cancer, has a doctor or other health professional ever recommended that you gain or lose weight?

- Yes, recommended lose weight
- Yes, recommended gain weight
- Recommended I maintain my weight
- No, haven't received any weight-related recommendations


BACK **NEXT**

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WEIGHT



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EXIT


About how much do you currently weigh without shoes? Please record in pounds.

Pounds


BACK **NEXT**

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HEIGHT_FT/HEIGHT_IN



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EXIT

	FEET	INCHES
About how tall are you without shoes?	<input type="text"/>	<input type="text"/>

BACK **NEXT**

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EXIT

Please indicate the extent to which you have experienced these symptoms or problems during the past week.

During the PAST WEEK...	Not at all	A little	Quite a bit	Very much
Did you have abdominal pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you have a bloated feeling in your abdomen/stomach?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you have problems with your clothes feeling too tight?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you experience any change in bowel habits?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Were you troubled by passing wind/gas/flatulence?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you felt full too quickly after beginning to eat?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

BACK

NEXT

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EXIT

Please indicate the extent to which you have experienced these symptoms or problems during the past week.

During the PAST WEEK...	Not at all	A little	Quite a bit	Very much
Have you had indigestion or heartburn?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you lost any hair?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did food and drink taste different than usual?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you felt weak in your arms or legs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you have aches and pains in your muscles or joints?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you have problems with hearing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you urinate frequently?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you had skin problems (e.g. itchy, dry)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

BACK

NEXT

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PSTWK_O THROUGH PSTWK_U



EXIT

Please indicate the extent to which you have experienced these symptoms or problems during the past week.

During the PAST WEEK...	Not at all	A little	Quite a bit	Very much
Did you have hot flashes?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Did you have night sweats?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you felt physically less attractive as a result of your disease or treatment?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have you been dissatisfied with your body?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How much has cancer been a burden to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
How much has your treatment been a burden to you?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Were you worried about your future health?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

BACK

NEXT

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INTRO5



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EXIT


The following section will ask about your family history of cancer and genetic testing.

BACK


NEXT

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RISK_TALK



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EXIT

Before you were diagnosed with ovarian cancer, had you ever talked to your doctor about your family history of cancer and what it might mean for your own health and cancer risk?


Yes

No


BACK **NEXT**

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FAM_OVAR



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EXIT

Have any other women in your family, that you are related to by blood, ever been diagnosed with ovarian cancer? *This could include your mother, sisters, grandmothers, aunts, daughters, granddaughters, nieces, or cousins.*

Yes


No

Don't know


BACK **NEXT**

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OVAR_NUM



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EXIT


How many women in your family, that you are **related to by blood**, have been diagnosed with ovarian cancer? *This could include your mother, sisters, grandmothers, aunts, daughters, granddaughters, nieces, or cousins.*

Number of relatives


BACK **NEXT**

If you experience technical issues, please call 1-###-###-#### or email xxxxx@norc.org for assistance.


FAM_BREAST



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EXIT


Have any other women in your family, that you are **related to by blood**, ever been diagnosed with breast cancer? *This could include your mother, sisters, grandmothers, aunts, daughters, granddaughters, nieces, or cousins.*

Yes
 No
 Don't know


BACK **NEXT**

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BREAST_NUM



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EXIT


How many women in your family, that you are **related to by blood**, have been diagnosed with breast cancer? *This could include your mother, sisters, grandmothers, aunts, daughters, granddaughters, nieces, or cousins.*

 Number of relatives


BACK **NEXT**

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UNDER50



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EXIT


How many of them were diagnosed when they were younger than age 50?

 Number of relatives


BACK **NEXT**

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MALE_BREAST



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EXIT

Have any men in your family, that you are related to by blood, ever been diagnosed with breast cancer?

Yes

No

Don't know

BACK **NEXT**

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GENETIC_REC



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EXIT

Genetic counseling involves an in-depth discussion with a trained genetic counselor, doctor, or nurse about your family's health history and your risk for having an inherited genetic mutation.

Has a doctor or other health professional ever recommended or referred you for genetic counseling for breast or ovarian cancer?

Yes

No

BACK **NEXT**

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GENETIC_YN



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CANCER
Relationship Survey



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EXIT

Have you ever received genetic counseling for breast or ovarian cancer risk?

Yes

No

Don't know

BACK **NEXT**

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GENETIC_WHEN



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CANCER
Relationship Survey



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EXIT

When did you receive genetic counseling?
Please select all that apply.

Before I was diagnosed


At the same time I was diagnosed

After I was diagnosed


BACK **NEXT**

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GENETIC_WHO



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EXIT


From whom did you receive genetic counseling?
Please select all that apply.

- Genetic counselor
- My regular or primary care doctor
- Nurse
- Cancer doctor or oncologist
- Gynecologist
- Other
- Don't know


BACK **NEXT**

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GENETIC_FAM



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EXIT

As far as you know, have any of your blood relatives received genetic counseling for breast or ovarian cancer risk?

- Yes
- No

BACK **NEXT**

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BRCA_YN



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EXIT

BRCA1 and BRCA2 are genes in a person's DNA that are associated with the risk of breast and ovarian cancer. There are genetic tests for mutations in BRCA1 and BRCA2, requiring a blood sample, saliva sample, or cheek swab, that can provide information about your risk for these cancers.


Have you ever had a BRCA1 or BRCA2 genetic test (sometimes called BRAC analysis) for cancer risk?

- Yes
- No
- Don't know


BACK **NEXT**

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BRCA_RESULTS



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EXIT


Did the results of your BRCA1/BRCA2 test indicate that you carry a mutation that would put you at increased risk for cancer?

- Yes
- No
- Inconclusive result (often called "Variant of Unknown Significance")
- Don't know


BACK **NEXT**

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INFLUENCE



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EXIT


Did the results of your genetic testing influence your cancer treatment in any of the following ways?

	Yes	No
Influenced surgery - had additional ovary or both ovaries removed	<input type="radio"/>	<input type="radio"/>
Influenced surgery - had one or both breasts removed (mastectomy)	<input type="radio"/>	<input type="radio"/>
Took a PARP inhibitor (Poly polymerase inhibitors, or PARP inhibitors - drugs that block DNA repair and may cause cancer cells to die. Examples: Olaparib, Niraparib)	<input type="radio"/>	<input type="radio"/>
Other, please specify:	<input type="radio"/>	<input type="radio"/>


BACK **NEXT**

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NOTEST



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EXIT


Why did you not receive genetic testing?
Please mark all that apply.

- I didn't know about it
- I didn't want to
- Too expensive
- My friends and family didn't think I needed it
- I was afraid of the result
- Someone else in my family had genetic testing
- My doctor never brought it up or offered testing
- Insurance wouldn't cover it
- My doctor didn't think I needed it
- I was afraid it would affect my health insurance coverage
- Other reasons


BACK **NEXT**

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BRCA_FAM



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EXIT

As far as you know, have any of your blood relatives received genetic testing for mutations in BRCA1 or BRCA2 genes?

Yes


No

Don't know


BACK **NEXT**

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BRCA_DESCNT



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EXIT

Studies show that BRCA1 and BRCA2 are more common in persons of Ashkenazi Jewish descent. Most people of Ashkenazi descent can trace their ancestry to Eastern Europe.

Are you and your family of Ashkenazi Jewish descent?

Yes


No

Don't know


BACK **NEXT**

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INTRO6



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EXIT

Next, we will ask you some questions about your experiences interacting with the medical system, while undergoing diagnosis and treatment for cancer, including your doctors, nurses, and other hospital or health system staff.

BACK


NEXT

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SIDEEFFECTS_A THROUGH SIDEEFFECTS_K



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EXIT

How much do you agree or disagree with each of the following statements?


	Strongly Disagree	Disagree	Agree	Strongly Agree	Doesn't Apply
My doctors talked to me about possible side effects before I started my cancer treatment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My doctors frequently asked if I was experiencing side effects associated with my cancer treatment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My doctors listened when I reported treatment-related side effects.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My doctors helped me deal with side effects from my treatment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My doctors gave me information on how I could manage treatment related side effects at home.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My treatment-related side effects were well managed.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I am satisfied with how my doctors managed my treatment-related side effects.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I had a hard time dealing with the side effects from my cancer treatment.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I looked for information online about how to manage my treatment-related side effects.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My doctors were not very helpful in dealing with the side effects from my cancer treatment(s).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I had all the support I needed in dealing with the side effects from my cancer treatment(s).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

BACK


NEXT

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INTRO7



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Research Workshop Survey



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EXIT

The following questions are about psychological and emotional care you may have received before, during, or after your cancer diagnosis and treatment.


BACK **NEXT**

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RELATIONS



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Research Workshop Survey



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EXIT


During your cancer diagnosis and treatment, did your doctor, nurse, or other health professional talk with you about how cancer may affect your emotions or relationships with other people?

- Yes
- No
- Don't know


BACK **NEXT**

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SERVICES_A THROUGH SERVICES_J AND HELPFUL_A THROUGH HELPFUL_J



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EXIT

During your cancer diagnosis and treatment, did you participate in or utilize any of the following services to help you cope psychologically or emotionally?


			If yes, how helpful was this?
	Yes	No	
Support Group	<input type="radio"/>	<input type="radio"/>	Select an answer... ▾
Professional Counseling	<input type="radio"/>	<input type="radio"/>	Select an answer... ▾
Talk to religious leaders or members of spiritual community	<input type="radio"/>	<input type="radio"/>	Very Helpful
Talk to doctors, nurses, or other health professionals	<input type="radio"/>	<input type="radio"/>	Somewhat Helpful
Talk to friends and family	<input type="radio"/>	<input type="radio"/>	A Little Helpful
Yoga or other exercise	<input type="radio"/>	<input type="radio"/>	Not At All Helpful
Meditation	<input type="radio"/>	<input type="radio"/>	Select an answer... ▾
Stress reduction or management techniques	<input type="radio"/>	<input type="radio"/>	Select an answer... ▾
Social worker	<input type="radio"/>	<input type="radio"/>	Select an answer... ▾
j The internet to get cancer education or support, like in an online community or forum	<input type="radio"/>	<input type="radio"/>	Select an answer... ▾
Camps, retreats, adventure programs or social activities that offer cancer education or support	<input type="radio"/>	<input type="radio"/>	Select an answer... ▾
Other, please specify:	<input type="radio"/>	<input type="radio"/>	Select an answer... ▾

BACK
NEXT

NOSUPPORT



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EXIT


Do any of the following reasons apply to why you didn't utilize any support services?
Please select all that apply.

- I didn't know these services were available.
- I didn't want to participate in these services or activities.
- I didn't have a way of getting to these activities or services.
- I didn't think I needed to participate in these activities.
- I couldn't afford to participate in these activities.



BACK
NEXT

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RELY_A THROUGH RELY_P



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EXIT

During your cancer diagnosis and treatment, did you have people you were able to rely on to...



	None of the time	A little of the time	Some of the time	Most of the time	All of the time
Remind or help you take medications?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Help you cook meals?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Help you complete household chores?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Help you run errands?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Provide transportation?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Help take care of children or pets?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Help with your caregiving responsibilities, like having someone take care of a sick friend or relative that you normally care for?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Accompany you to doctor's appointments?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Help you complete work responsibilities?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Help take care of important duties, such as pay bills?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Help you financially?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Confide in or talk to about how you were feeling or doing?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Provide comfort or support in a time of need?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Share your worries or fear with?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Help you take your mind off things?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Have a good time or do something enjoyable with?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

BACK
NEXT

INTRO8



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Control and Prevention


EXIT

The following questions are about your health insurance coverage during your cancer diagnosis and treatment.


BACK
NEXT

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INSURE_YN



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EXIT

Did you have any form of health insurance that paid for all or part of your medical care, tests, or cancer treatments?


Yes

No


BACK **NEXT**

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INSURE_TYPE



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EXIT

What kind of health insurance did you have at the time of your ovarian cancer diagnosis and treatment?


Please select all that apply.

<input type="checkbox"/> Health insurance through your (or your spouse's) employer	<input type="checkbox"/> Indian Health Service
<input type="checkbox"/> Private health insurance, individually purchased	<input type="checkbox"/> State-sponsored health plan
<input type="checkbox"/> Medicare	<input type="checkbox"/> Other government program
<input type="checkbox"/> Medi-Gap	<input type="checkbox"/> Single service plan (e.g. dental, vision, prescription)
<input type="checkbox"/> Medicaid	<input type="checkbox"/> No coverage of any type
<input type="checkbox"/> SCHIP (State Children's Health Insurance Program)	<input type="checkbox"/> Don't know
<input type="checkbox"/> Military health care (e.g. TRICARE/VA/CHAMP-VA)	


BACK **NEXT**

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INSREF_APPT



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EXIT


Was there ever a time when health insurance refused to cover a medical appointment for your cancer with the doctor or facility of your choice?

- Yes
- No
- Don't know
- Does not apply


BACK **NEXT**

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INSREF_OPIN



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EXIT


Was there ever a time when health insurance refused to cover a second opinion about your cancer?

- Yes
- No
- Don't know
- Does not apply


BACK **NEXT**

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INSREF_TEST



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EXIT


Was there ever a time when health insurance refused to cover a test or procedure recommended by your doctors for your cancer care and treatment?

- Yes
- No
- Don't know
- Does not apply


BACK **NEXT**

If you experience technical issues, please call 1-####-#### or email xxxxx@norc.org for assistance.


INSREF_MED



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EXIT


Was there ever a time when health insurance refused to cover a medication prescribed for your cancer care?

- Yes
- No
- Don't know
- Does not apply


BACK **NEXT**

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STAYJOB



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EXIT


During your cancer diagnosis and treatment, did you ever stay at a job in part because you were concerned about losing your health insurance?

- Yes
- No
- Don't know
- Does not apply


BACK **NEXT**

If you experience technical issues, please call 1-###-###-#### or email xxxxx@norc.org for assistance.


LOSE_CANC



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EXIT


Were you ever concerned about losing your health insurance because of your cancer?

- Yes
- No
- Does not apply


BACK **NEXT**

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UNINSURED



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EXIT


At any point during your cancer diagnosis or treatment, were you uninsured or did you lose your health insurance coverage?

- Yes
- No
- Don't know
- Does not apply


BACK **NEXT**

If you experience technical issues, please call 1-###-###-#### or email xxxxx@norc.org for assistance.


DENY_INS



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EXIT


Were you ever denied health insurance coverage because of your cancer?

- Yes
- No
- Don't know
- Does not apply


BACK **NEXT**

If you experience technical issues, please call 1-###-###-#### or email xxxxx@norc.org for assistance.


INTRO9



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EXIT

The following questions are about your occupational status and experiences with work before, during, and after your cancer treatment.


BACK **NEXT**

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EMPLOY



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EXIT


At the time of your ovarian cancer diagnosis, what was your employment status?

- Employed full-time
- Employed part-time
- Self-employed
- Unemployed and looking for work
- Unemployed and not looking for work
- Homemaker
- Retired
- On disability
- Other


BACK **NEXT**

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EMP_TYPE



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EXIT


At the time of your ovarian cancer diagnosis, what was your employment status?

- Employed full-time
- Employed part-time
- Self-employed
- Unemployed and looking for work
- Unemployed and not looking for work
- Homemaker
- Retired
- On disability
- Other


BACK **NEXT**

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LEAVE_YN



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EXIT


Did you take any leave or time off from work for any of your cancer treatment and/or recovery?

- Yes
- No


BACK **NEXT**

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LEAVE_TYPE



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EXIT


What kind of leave or time off did you take during your treatment and/or recovery?
Please select all that apply.

- Paid sick leave
- Unpaid sick leave
- Other paid time off
- Family Medical Leave Act (FMLA)
- Disability leave
- There was no time off
- Quit job
- Other, please specify:


BACK **NEXT**

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WORKAFTER_YN



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Relationship Survey



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EXIT


After your treatment and recovery, did you continue working for pay?


- Yes
- No


BACK **NEXT**

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WORKTX_AFTER

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EXIT

After your treatment and recovery, did you continue working for pay?


Yes


No


BACK **NEXT**

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TRTMNT_AFTER

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EXIT

After your treatment and recovery, did you...

Retire

Go on disability

Quit working

Lose your job or get fired

Continue looking for work

Other

BACK **NEXT**

If you experience technical issues, please call 1-###-###-#### or email xxxxx@norc.org for assistance.

DISCRIM

The screenshot shows a survey interface with logos for the CDC, Ovarian Cancer Research Fund, and NORC at the University of Chicago. The question asks if the respondent has ever experienced workplace discrimination due to their cancer diagnosis. There are radio buttons for 'Yes' and 'No', and 'BACK' and 'NEXT' buttons. A red 'EXIT' button is also present. A footer provides technical support information.

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EXIT

Did you ever feel like you were experiencing discrimination in your workplace resulting from your cancer diagnosis, treatment, and its lasting effects?

Yes

No

BACK

NEXT

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INTRO10

The screenshot shows an introduction slide for a survey. It features the same logos as the previous slide. The text indicates that the next question will be about the financial impact of cancer. There are 'BACK' and 'NEXT' buttons, and a red 'EXIT' button. A footer provides technical support information.

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EXIT


Next, we will ask about the possible financial impact cancer has had on your life.

BACK


NEXT

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FINANCES



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EXIT


To what degree has cancer caused financial problems for you and your family?

- A lot
- Some
- A little
- None at all


BACK **NEXT**

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BORROW



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EXIT

Have you or has anyone in your family had to borrow money or go into debt because of your cancer or its treatment?

- Yes
- No


BACK **NEXT**

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BANKRUPT



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EXIT

Did you or your family ever file for bankruptcy because of your cancer or its treatment?


Yes

No


BACK **NEXT**

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SACRIFICE



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Survivorship Survey



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EXIT

Have you or your family ever had to make other kinds of financial sacrifices because of your cancer or its treatment?


Yes, Please describe what kind of financial sacrifices:

No


BACK **NEXT**

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MEDBILLS



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EXIT

Have you ever worried about having to pay large medical bills related to your cancer?


Yes

No


BACK **NEXT**

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UNABLE



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EXIT

Keeping in mind medical visits for your cancer, its treatment, or the lasting effects of that treatment, have you ever been unable to cover your share of the costs of those visits?


Yes

No


BACK **NEXT**

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OUTOFFPOCKET



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EXIT


Overall, how much do you think you or your family spent out-of-pocket on co-pays, medical bills, and other expenses related to your cancer, its treatment, and/or the lasting effects of that treatment?

- Less than \$2,000
- Between \$2,000 and \$5,000
- Between \$5,001 and \$10,000
- Between \$10,001 and \$25,000
- More than \$25,000


BACK **NEXT**

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INTRO11



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EXIT

We are also interested in learning about other medical conditions, aside from cancer, that you may have and any medications, either prescription or over-the-counter, you may be taking to address health issues.

BACK **NEXT**

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OTHMED_A THROUGH OTHMED_M/DIAG_A THROUGH DIAG_M

EXIT

During your cancer diagnosis and treatment, did you participate in or utilize any of the following services to help you cope psychologically or emotionally?

				Diagnosis before or after ovarian cancer treatment?
	Yes	No	Don't Know	
Hypertension (High blood pressure)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Select an answer... ▾
High cholesterol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Select an answer... ▾
Heart problems (such as heart attack, coronary artery disease, congestive heart failure, irregular heartbeat, etc.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Before After Select an answer... ▾
Stroke, including mini-strokes or blood clots in the brain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Select an answer... ▾
Diabetes, high blood sugar, or sugar in the urine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Select an answer... ▾
Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Select an answer... ▾
Osteoporosis or Osteopenia (loss of bone mass, fragile or soft bones)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Select an answer... ▾
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Select an answer... ▾
Emphysema, chronic bronchitis, or chronic obstructive pulmonary disease (COPD)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Select an answer... ▾
Kidney disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Select an answer... ▾
Stomach and/or intestinal problems, such as Crohn's disease, ulcers, or inflammatory bowel disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Select an answer... ▾
Anemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Select an answer... ▾
Other, please specify:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Select an answer... ▾

BACK
NEXT

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DEPRESS





EXIT


Have you ever taken any prescription medication for depression? *Examples include Zoloft, Prozac, Sarafem, Lexapro, Celexa, Paxil, Effexor, Cymbalta, or Wellbutrin.*

Yes
 No
 Don't know


BACK
NEXT

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DEPRESS_BDA



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EXIT

Did you take this medication before, during, or after your cancer diagnosis and treatment?
Please select all that apply.

- Took medication BEFORE cancer diagnosis and treatment
- Took medication DURING cancer diagnosis and treatment
- Took medication AFTER cancer diagnosis and treatment

BACK **NEXT**

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DEPRESS_CURR



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EXIT


Are you currently taking medication for depression?

- Yes
- No
- Don't know


BACK **NEXT**

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DEPRESS_RX



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EXIT


Who wrote the prescription for your anti-depressant medication?

- Primary care doctor
- Oncologist
- Psychiatrist
- Other, please specify:


BACK **NEXT**

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ANXIETY



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EXIT


Have you ever taken prescription medication for anxiety or for feeling worried, anxious, or nervous?
Examples include Xanax, Niravam, Klonopin, Ativan, Valium, Vanspar, or a beta-blocker like Bevbloc or propranolol.

- Yes
- No
- Don't know


BACK **NEXT**

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ANXIETY_BDA



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EXIT


Did you take this medication before, during, or after your cancer diagnosis and treatment?
Please select all that apply.

- Took medication BEFORE cancer diagnosis and treatment
- Took medication DURING cancer diagnosis and treatment
- Took medication AFTER cancer diagnosis and treatment


BACK **NEXT**

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ANXIETY_CURR



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EXIT

Are you currently taking medication to treat anxiety?

- Yes
- No
- Don't know

BACK **NEXT**

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ANXIETY_RX



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EXIT


Who wrote the prescription for your anti-anxiety medication?

- Primary care doctor
- Oncologist
- Psychiatrist
- Other, please specify:


BACK **NEXT**

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PAIN_OTC



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EXIT


Are you currently taking any over-the-counter, or non-prescription, medication to help you deal with pain? Examples include Advil, Tylenol, or Motrin.

- Yes
- No


BACK **NEXT**

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PAINMED



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EXIT


Are you currently taking any *prescription* medications to help you deal with pain? *Examples include Hydrocodone, Percocet, or Vicodin.*

Yes
 No


BACK **NEXT**

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PAINMED_WHY



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EXIT


Is the pain for which you take these medications for due to your cancer, its treatment, or its late and long-term side effects?

Yes
 No


BACK **NEXT**

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PAINMED_BDA



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EXIT


Did you start taking prescription pain medication before, during, or after your ovarian cancer diagnosis and treatment?
Please select all that apply

- Took medication BEFORE ovarian cancer diagnosis and treatment
- Took medication DURING ovarian cancer diagnosis and treatment
- Took medication AFTER ovarian cancer diagnosis and treatment


BACK **NEXT**

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CHOLEST



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EXIT


Have you ever taken prescription medication to lower your cholesterol? *These medications are usually called statins. Examples include Zocor, Lipitor, Crestor, or Pravachol/Prevastin.*

- Yes
- No
- Don't know


BACK **NEXT**

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CHOLEST_BDA



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EXIT

Did you take this medication before, during, or after your cancer diagnosis or treatment?
Please select all that apply.

- Took medication BEFORE cancer diagnosis and treatment
- Took medication DURING cancer diagnosis and treatment
- Took medication AFTER cancer diagnosis and treatment

BACK **NEXT**

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CHOLE_CURR



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EXIT

Are you currently taking medications to help lower your cholesterol?

- Yes
- No
- Don't know

BACK **NEXT**

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BP_EVER



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EXIT


Have you ever taken prescription medication to help lower your blood pressure? *Examples include Lisinopril or Prinivil, Amlodipine or Norvasc, Metoprolol or Toprol, and Losartan or Cozaar.*

Yes
 No
 Don't know


BACK **NEXT**

If you experience technical issues, please call 1-###-###-#### or email xxxxx@norc.org for assistance.


BP_BDA



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Research Award



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EXIT

Did you take this medication before, during, or after your cancer diagnosis and treatment?
Please select all that apply.

Took medication BEFORE cancer diagnosis and treatment
 Took medication DURING cancer diagnosis and treatment
 Took medication AFTER cancer diagnosis and treatment

BACK **NEXT**

If you experience technical issues, please call 1-###-###-#### or email xxxxx@norc.org for assistance.

BP_CURR



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EXIT

Are you currently taking medication to help lower your blood pressure?

Yes

No

Don't know

BACK **NEXT**

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INSULIN



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EXIT

Have you ever taken insulin by injection or an oral prescription medication for diabetes? *Examples of oral medications include Metformin or Glucophage, Actos, Januvia, or Invokana.*

Yes

No

Don't know

BACK **NEXT**

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INSULIN_BDA



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EXIT

Did you take diabetes medication before, during, or after your cancer diagnosis and treatment?
Please select all that apply.

- Took medication BEFORE cancer diagnosis and treatment
- Took medication DURING cancer diagnosis and treatment
- Took medication AFTER cancer diagnosis and treatment

BACK **NEXT**

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INSULIN_CURR



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EXIT

Are you currently taking medication for diabetes?

- Yes
- No
- Don't know

BACK **NEXT**

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SLEEP



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EXIT

Have you **ever** taken a prescription medication to help you sleep? *Examples include Silenor, Lunesta, Ambien, or Restoril*

Yes


No

Don't know


BACK **NEXT**

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SLEEP_BDA



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CANCER
Survivorship Survey



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EXIT

Did you take this medication before, during, or after your cancer diagnosis and treatment?
Please select all that apply.

Took medication BEFORE cancer diagnosis and treatment

Took medication DURING cancer diagnosis and treatment

Took medication AFTER cancer diagnosis and treatment

BACK **NEXT**

If you experience technical issues, please call 1-###-###-#### or email xxxxx@norc.org for assistance.

SLEEP_CURR

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EXIT

Are you currently taking medication to help you sleep?

Yes


No


Don't know


BACK **NEXT**

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INTRO12

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EXIT

The following questions are about your current health and well-being.


BACK **NEXT**


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GLOBAL01 THROUGH GLOBAL05, GLOBAL 09



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EXIT


Please respond to each item by marking one box per row.

	Excellent	Very Good	Good	Fair	Poor
In general, would you say your health is:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In general, would you say your quality of life is:	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In general, how would you rate your physical health?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In general, how would you rate your mental health, including your mood and your ability to think?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In general, how would you rate your satisfaction with your social activities and relationships?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In general, please rate how well you carry out your usual social activities and roles. (<i>This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.</i>)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>


BACK
NEXT


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GLOBAL06



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EXIT


To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?

- Completely
- Mostly
- Moderately
- A little
- Not at all


BACK
NEXT

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GLOBAL10



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EXIT

In the past 7 days, how often have you been bothered by emotional problems such as feeling anxious, depressed, or irritable?

- Never
- Rarely
- Sometimes
- Often
- Always

BACK **NEXT**

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GLOBAL08



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EXIT


In the past 7 days, how would you rate your fatigue on average?

- None
- Mild
- Moderate
- Severe
- Very severe


BACK **NEXT**

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GLOBAL07



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EXIT


In the past 7 days, how would you rate your pain on average?

- 0 No Pain
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10 Worst Pain Imaginable


BACK **NEXT**

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SLEEP_SATIS



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EXIT




How satisfied are you with the sleep you are getting?

- Very satisfied
- Somewhat satisfied
- Neither satisfied nor dissatisfied
- A little satisfied
- Not at all satisfied

BACK **NEXT**

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PAST4_A THROUGH PAST4_J



EXIT




In the past 4 weeks...

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
About how often did you feel tired for no good reason?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
About how often did you feel nervous?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
About how often did you feel so nervous that nothing could calm you down?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
About how often did you feel hopeless?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
About how often did you feel restless or fidgety?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
About how often did you feel so restless you could not sit still?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
About how often did you feel depressed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
About how often did you feel that everything was an effort?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
About how often did you feel so sad that nothing could cheer you up?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
About how often did you feel worthless?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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INTRO14




EXIT

The final set of questions is about you.


BACK **NEXT**

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SCHOOL



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EXIT


What is the highest grade or level of schooling you completed?

- Grade 11 or less
- Completed high school
- Post high school training other than college (vocational or technical)
- Some college
- College graduate
- Postgraduate


BACK **NEXT**

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MARITAL



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EXIT

What is your marital status?

- Married
- Living as married
- Divorced/Separated
- Widowed
- Single, never been married

BACK **NEXT**

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ETHNICITY



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EXIT

Are you of Hispanic, Latino/a, or Spanish origin?


Yes

No


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ETH_GROUP



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EXIT

Which group are you from?

Mexican, Mexican American, Chicano/a

Puerto Rican

Cuban

Dominican


Central or South American

Other Hispanic, Latino/a, or Spanish origin


BACK **NEXT**

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RACE



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EXIT


What is your race?
You may select multiple categories.

- White
- Black or African American
- Asian
- Native Hawaiian or Pacific Islander
- American Indian or Alaska Native


BACK **NEXT**

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EMPLOY_CURR



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EXIT


What is your current occupational status?

- Employed (full-time, part-time, or self-employed)
What kind of work are you currently doing?
For example, teacher, postal worker, nurse, etc.
- Unemployed
- Homemaker
- Student
- Retired
- Disabled
- Other, please specify:


BACK **NEXT**

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HI_TYPE



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EXIT


What kind of health insurance do you have?
Please select all that apply.

<input type="checkbox"/> Health insurance through your (or your spouse's) employer	<input type="checkbox"/> Indian Health Service
<input type="checkbox"/> Private health insurance, individually purchased	<input type="checkbox"/> State-sponsored health plan
<input type="checkbox"/> Medicare	<input type="checkbox"/> Other government program
<input type="checkbox"/> Medi-Gap	<input type="checkbox"/> Single service plan (e.g. dental, vision, prescription)
<input type="checkbox"/> Medicaid	<input type="checkbox"/> No coverage of any type
<input type="checkbox"/> SCHIP	<input type="checkbox"/> Don't know
<input type="checkbox"/> Military health care (TRICARE/VA/CHAMP-VA)	


BACK **NEXT**

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NOHI_12MOS



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EXIT

In the past 12 months, was there any time when you did not have any health insurance coverage?

Yes
 No
 Don't know

BACK **NEXT**

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CHILDREN



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EXIT

Do you have any children?

Yes

No

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CHILD_NUM



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EXIT


How many children do you have?

Number of Children


BACK **NEXT**

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UNDER18



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Research Survey



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EXIT


How many are under age 18?

Number of Children under 18


BACK **NEXT**

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INCOME



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EXIT

Thinking about all the members of your family living in your household, what is your combined annual income, meaning the total pre-tax income from all sources earned in the past year?

- Less than \$20,000
- \$21,000 to \$49,999
- \$50,000 to \$74,999
- \$75,000 to \$99,999
- \$100,00 to \$199,999
- \$200,000 or more
- Don't know

BACK **NEXT**

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STATE



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EXIT


What state do you live in?

ALABAMA ▼

BACK **NEXT**

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ZIP_CODE



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EXIT

What zip code do you live in?


BACK **NEXT**

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INCENT2



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EXIT

Congratulations, you are eligible for a \$10 Amazon gift code. Below is your gift code number:

[GIFTCODE DISPLAYED HERE]

Would you like us to email or mail the above giftcode number to you?

- Email only
- Mail only
- I do not want the giftcode sent to me

BACK **NEXT**

If you experience technical issues, please call 1-###-###-#### or email xxxxx@norc.org for assistance.

WEBINEM1



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EXIT

Please enter your email address:


BACK **NEXT**

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WEBINEM2



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EXIT

Please reenter your email address:


BACK **NEXT**

If you experience technical issues, please call 1-###-###-#### or email xxxxx@norc.org for assistance.


INC_ADDRESS



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EXIT

Is this your correct mailing address?

Street:

Apartment:

City:


State:

Zip Code:


BACK **NEXT**

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NETWORK1



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EXIT


Are there any other women you know that have been diagnosed with cancer of the ovary, fallopian tube, or peritoneum who may be interested in participating in this study?

- Choice 1
- Choice 2
- Don't know
- Prefer not to answer


BACK **NEXT**

If you experience technical issues, please call 1-###-###-#### or email xxxxx@norc.org for assistance.


NETWORK2



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EXIT

Are these women who are:

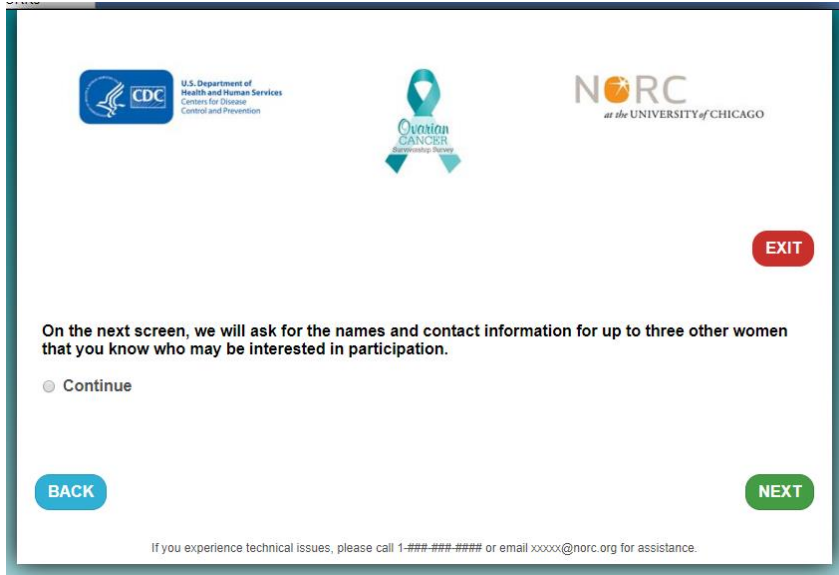
- at least 18 years of age,
- have been diagnosed with ovarian, fallopian tube, or primary peritoneal cancer,
- and have undergone some form of treatment?

- Yes
- No
- Don't know
- Prefer not to answer


BACK **NEXT**

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NETWORK3



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EXIT

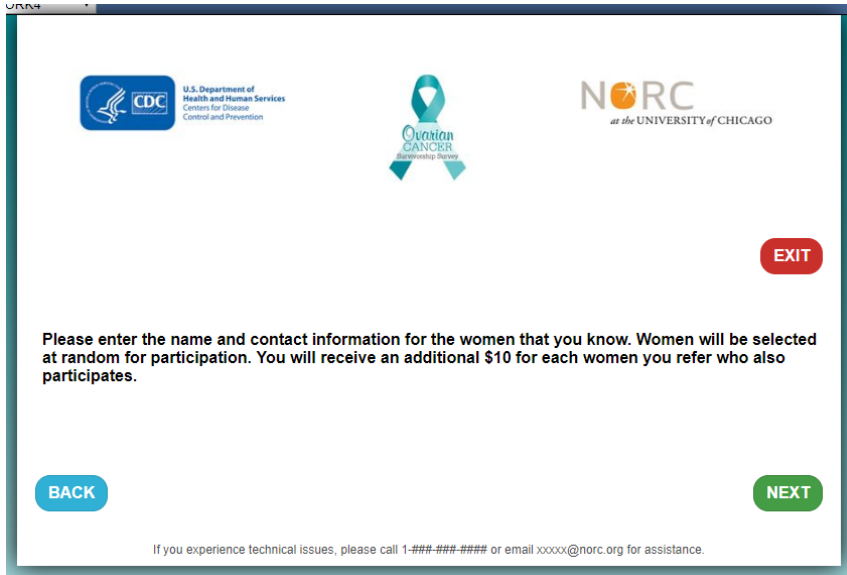
On the next screen, we will ask for the names and contact information for up to three other women that you know who may be interested in participation.

Continue


BACK **NEXT**

If you experience technical issues, please call 1-###-###-#### or email xxxxxx@norc.org for assistance.

NETWORK4



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EXIT

Please enter the name and contact information for the women that you know. Women will be selected at random for participation. You will receive an additional \$10 for each women you refer who also participates.

BACK **NEXT**

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WOMAN_1



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EXIT

Name:

Street:

Apartment:

City:

State:

Zip Code:

Email address:

BACK **NEXT**

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WOMAN_2



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EXIT

Name:

Street:

Apartment:

City:

State:

Zip Code:

Email address:


BACK **NEXT**

If you experience technical issues, please call 1-###-###-#### or email xxxxx@norc.org for assistance.


WOMAN_3



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EXIT

Name:

Street:

Apartment:

City:

State:

Zip Code:

Email address:

BACK **NEXT**

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THANKYOU



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EXIT

Thank you for your time and your effort completing this survey. We appreciate your assistance with this important study.

BACK **NEXT**

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