

TELL YOUR BREAST CANCER TEAM ABOUT **YOURSELF**

Tip: Your answers are very likely to change over the course of treatment and time. You are encouraged to complete this checklist regularly before each follow-up appointment/check-up.



YOUR MIND

Healthy Aging

How do you maintain your overall mental health?

Yes

No

1. Meditate
2. Exercise
3. Read or listen to a book/audiobook
4. Listen to music or a podcast
5. Have one or more hobbies
6. Play an instrument
7. Watch TV or go to the movies
8. Other: _____



Memory Check

Do you have any of the following symptoms?⁶

Yes

No

1. Memory changes that affect your day-to-day abilities ☐ Yes ☐ No
2. Difficulty doing familiar tasks such as preparing a meal or getting dressed
3. Changes in communication such as forgetting words or using words that don't fit the conversation
4. Confused on the day of the week or getting lost in a familiar place
5. Not recognizing something that can put your health and safety at risk
6. Trouble understanding numbers and symbols such as having trouble paying bills
7. Misplacing things and putting things in places they shouldn't be such as a shoe in the fridge
8. Changes in mood or behaviour
9. Losing interest in family, friends and favourite activities
10. Having trouble seeing things correctly such as having trouble putting a glass on a table



Mood and Anxiety Check

Over the last 2 weeks, how often have you been bothered by the following problems?

Not at all

Several days

More than 1 a week

Almost every day

Little interest or pleasure in doing things

Feeling down, depressed or hopeless

Feeling nervous, anxious or on edge

Not being able to stop or control worrying

Diagnoses Check

Have you ever been diagnosed with any of the following:

Yes

No

1. Depression
2. Anxiety
3. Bipolar disorder
4. Schizophrenia
5. Substance use disorder
6. Post-traumatic stress disorder (PTSD)
7. Dementia or Alzheimer's disease
8. Other: _____



YOUR MOBILITY

Mobility Check

Please answer these two questions:⁷

Yes

No

1. Because of underlying health or physical reasons, do you have difficulty climbing up 10 steps? Or walking 0.5 km?
2. Because of underlying health or physical reasons, have you modified the way you climb 10 steps or walk 0.5 km? Either by changing the method or frequency of these activities.

Independence check

Please answer the following questions:⁸

Yes

No

1. Are you older than 85 years?
2. In general, do you have any health problems that require you to limit your activities?
3. Do you need someone to help you on a regular basis?
4. In general, do you have any health problems that require you to stay at home?
5. If you need help, can you count on someone close to you?
6. Do you regularly use a cane, walker, or wheelchair to move about?



Independence check, continued

Please answer the following questions:⁸

Yes

No

7. If you have stairs in your home, can you manage them independently?
8. Do you have other specialized equipment in your home such as grab bars, raised toilet seats, or a bath bench?

Function check

Do you need help with or has anyone taken over any of your usual activities?:⁹

Yes

No

1. Dressing
2. Eating
3. Walking around
4. Using the toilet
5. Showering or bathing
6. Other hygiene activities (for example, brushing teeth, hair care, etc.)
7. Shopping
8. Housework including laundry
9. Paying your bills



Function check, continued

Do you need help with or has anyone taken over any of your usual activities?:⁹

Yes

No

10. Preparing your food

11. Transportation

12. Help with your medications

Fall check

Yes

No

Have you had any falls in the past year?:⁹

If you have fallen, how often have you fallen in the last year? Is there a certain time of the day when you fall the most? Do you use a personal fall alarm system? Have you sustained any injuries from a fall?

Can you describe your fall(s):



YOUR HEALTH

Rate your health

Very poor

Poor

Average

Good

Excellent

Compared to the health of other people your age, is your health:

Much worse

Worse

About the same

Better

Much better

Medical condition check

Have you been diagnosed with any of the following health conditions:¹⁰

High blood pressure

Osteoarthritis

Heart disease

Kidney disease

Diabetes

Osteoporosis

Chronic obstructive pulmonary disease (COPD)

Asthma

What other health conditions have you been diagnosed with?

[illegible]



YOUR GOALS AND MAIN CONCERNS

When looking at your cancer treatment, what are your main goals? (This could include things such as long life, living in my home, not being a burden to my family, low or no side effects, better quality of life, low or no pain, etc.)

Main concern check

Please check the top two concerns that you have when treating your breast cancer:

Treatment side effects – short-term

Treatment side effects – long-term

Emotional issues of being diagnosed with breast cancer

The impact of treatment on living in my own home

Impact of treatment on my quality of life

Survival

Other: _____