TELL YOUR BREAST CANCER TEAM ABOUT **YOURSELF**

Canadian Breast Cancer Network (CBCN)

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?[9]

	Yes	No
1. Memory changes that affect your day-to-day abilities	○	○
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:[10]

	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:[11]

	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[11]

	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?:[12]

	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?:[12]

	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?:[12]		

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?

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Can you describe your fall(s):

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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:[13]

- 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?

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YOUR MEDICATIONS

Please list all the medications that you are currently taking. Please include all prescribed medications, any over-the-counter products, vitamins, herbs or supplements:

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.)

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Main concern check

Please check the top two concerns that you have when treating your breast cancer:[13]

- 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: ____