

## MODIFIED ROTTERDAM EXERCISE AND CANCER QUALITY OF LIFE SURVEY

The modified Rotterdam questionnaire is designed to gather information on people who participated in exercise programs within a health club, gym, or community program during or after their cancer treatment. Comparisons will be made with those who exercise "in the real world" as opposed to collecting data from medical research programs. The survey contains information pertaining to almost every type of exercise that may be performed in this setting. It takes approximately 10 minutes to complete, and it is important to fill out all of the information pertaining to your own program (especially medical information). If there are any questions that you need from your doctor, please call and obtain information from your medical chart. If you have any questions from the fitness aspect, please discuss them with the exercise/health professional from whom you received this form.

### GENERAL INFORMATION

Name: \_\_\_\_\_ Date: \_\_\_\_\_ Age: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_  
% Body Fat: \_\_\_\_\_ BMI: \_\_\_\_\_ ROM: \_\_\_\_\_

### CANCER/MEDICAL INFORMATION

Date of diagnosis: \_\_\_\_\_ Type of cancer: \_\_\_\_\_  
Area of the body: \_\_\_\_\_ Type of surgery performed: \_\_\_\_\_  
Type of radiation/chemotherapy: \_\_\_\_\_  
Times per month: \_\_\_\_\_ Length of oncology treatment: \_\_\_\_\_

### EXERCISE INFORMATION

Is your doctor aware of your exercise program? YES \_\_\_\_\_ NO \_\_\_\_\_  
If yes, what were his/her comments? \_\_\_\_\_  
Did he/she ever advise against exercise? YES \_\_\_\_\_ NO \_\_\_\_\_  
If so, what were the reasons? \_\_\_\_\_

Type of exercise program in general you participated in during or after your treatment (check all that apply):

aerobics \_\_\_\_\_ strength \_\_\_\_\_ sports (list) \_\_\_\_\_  
stretching/yoga \_\_\_\_\_ swimming \_\_\_\_\_

Type of aerobic training program you performed during or after treatment (check all that apply):

aerobic machines \_\_\_\_\_ walking \_\_\_\_\_ step aerobics \_\_\_\_\_  
jogging \_\_\_\_\_ aerobic dance \_\_\_\_\_ other (list) \_\_\_\_\_  
times per week \_\_\_\_\_ time length \_\_\_\_\_ describe program \_\_\_\_\_  
sports competition \_\_\_\_\_ aqua jogging \_\_\_\_\_ Average training heart rate: \_\_\_\_\_  
What is your training heart rate zone? \_\_\_\_\_ ( $220 - \text{age} \times .60 - .85 = \_\_\_$ )

Type of strength training program you performed (if you did so)

free weights only \_\_\_\_\_ machines only \_\_\_\_\_  
combination of both \_\_\_\_\_ others (rubber tubing, manual resistance, etc) \_\_\_\_\_

Specific weight training you performed \*[DB = dumb bell]

UPPER BODY AREA (check stations used)

bench/chest press \_\_\_\_\_ Nautilus chest, \_\_\_\_\_  
dumbbell chest \_\_\_\_\_ cable chest \_\_\_\_\_

SHOULDER AREA

shoulder press \_\_\_\_\_ DB shoulder flies \_\_\_\_\_  
lateral raise \_\_\_\_\_ DB shoulder press \_\_\_\_\_

BACK AREA

back - lat pull \_\_\_\_\_ low rows \_\_\_\_\_

DB rows \_\_\_\_\_ T-rows \_\_\_\_\_

upward rows \_\_\_\_\_ others \_\_\_\_\_

ARMS/TORSO

arms – biceps \_\_\_\_\_ triceps \_\_\_\_\_

forearms \_\_\_\_\_ torso \_\_\_\_\_

ABDOMINALS

(obliques, trunk): \_\_\_\_\_

LOWER BODY

leg squats \_\_\_\_\_ calves \_\_\_\_\_

leg press \_\_\_\_\_ leg extension \_\_\_\_\_

leg curl \_\_\_\_\_ inner thigh \_\_\_\_\_

outer thigh \_\_\_\_\_ total hip \_\_\_\_\_

lunges \_\_\_\_\_ other (list) \_\_\_\_\_

Number of sets you usually performed: \_\_\_\_\_ sets of \_\_\_\_\_ reps

Did you break for water? YES \_\_\_\_\_ NO \_\_\_\_\_

(if yes, how often?) \_\_\_\_\_

Did you perform any other types of exercise during your treatment?

Yoga YES \_\_\_\_\_ NO \_\_\_\_\_

Stretching YES \_\_\_\_\_ NO \_\_\_\_\_

Home exercise YES \_\_\_\_\_ NO \_\_\_\_\_

Days per week? \_\_\_\_\_

Did you experience any other medical concerns during your treatment  
(or one week after each treatment)?

excess fatigue YES \_\_\_\_\_ NO \_\_\_\_\_

nausea YES \_\_\_\_\_ NO \_\_\_\_\_

cramps YES \_\_\_\_\_ NO \_\_\_\_\_

(if yes, list location): \_\_\_\_\_

dizziness YES \_\_\_\_\_ NO \_\_\_\_\_

depression YES \_\_\_\_\_ NO \_\_\_\_\_

other (list) \_\_\_\_\_

Did you sustain any injuries during exercise? YES \_\_\_\_\_ NO \_\_\_\_\_

If so, please list \_\_\_\_\_

Did you work out with a partner? YES \_\_\_\_\_ NO \_\_\_\_\_

With a personal trainer/instructor? YES \_\_\_\_\_ NO \_\_\_\_\_

Was your trainer knowledgeable about exercise and  
cancer information and training programs? YES \_\_\_\_\_ NO \_\_\_\_\_

Did you record your exercise program in a log book or folder? YES \_\_\_ NO \_\_\_

Did you feel that your aerobic training helped you with your cancer treatments? YES \_\_\_ NO \_\_\_

Comment (How so?): \_\_\_\_\_

### NUTRITIONAL INFORMATION

Are you on any special nutritional program? \_\_\_\_\_

Are you using any supplement (protein powder, Ensure, etc) \_\_\_\_\_

Are you taking any vitamin supplements (list types and amounts): \_\_\_\_\_

How many times do you eat during the day (meals + snacks): \_\_\_\_\_

How many calories (approximately) do you take in each day?: \_\_\_\_\_

### PSYCHO-SOCIAL INFORMATION

This section of the Rotterdam Exercise survey takes approximately 15 minutes to complete. Please make an effort to answer all of the questions. You may refuse to answer a question if you choose. This survey is modified so that an "X" indicates how you felt before you began your exercise program, and an "O" indicates your responses at the end of the exercise program, at 10 or 20 weeks. If you feel that there is no change in your response, place an "Ø" in the Space. Key: "X"=pre-exercise program, "O"=post-exercise program, Ø=no change.

1	2	3	4	5	6	7	8	9
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### SECTION I: FUNCTIONAL LIVING INDEX

1. How well are you coping with everyday stress?

1	2	3	4	5	6	7	8	9
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NOT WELL

VERY WELL

2. How much time do you spend thinking about your illness?

1	2	3	4	5	6	7	8	9
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CONSTANTLY

NEVER

3. Rate your ability to maintain your usual recreational or leisure activities.

1	2	3	4	5	6	7	8	9
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UNABLE

ABLE

4. Has nausea affected your daily functioning?

1	2	3	4	5	6	7	8	9
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A GREAT DEAL

NOT AT ALL

5. How well do you feel on a daily average?

1	2	3	4	5	6	7	8	9
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EXTREMELY POOR

EXTREMELY WELL

6. Do you feel well enough to perform activities of daily living? (household tasks, preparing meals, repairs, etc.)

1	2	3	4	5	6	7	8	9
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NOT ABLE

VERY ABLE

7. Rate in your opinion how disruptive your cancer has been to those closest to you in the past 4 months.

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>
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TOTALLY DISRUPTIVE NO DISRUPTION

8. How uncomfortable do you feel on a daily basis?

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>
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VERY UNCOMFORTABLE NOT AT ALL

9. How much does pain or discomfort interfere with your daily activities?

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>
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GREAT DEAL NOT AT ALL

10. How much of your usual household tasks are you able to complete?

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>
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NONE ALL

11. How much nausea have you experienced in the past 4 months (in general?):

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>
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A GREAT DEAL NONE

12. What is your outlook of the future?

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>
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CONSTANTLY TERRIFIED NOT AFRAID

13. Rate your confidence in your prescribed course of treatment (medical treatment - doctor visits, chemotherapy)

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>
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NO CONFIDENCE VERY CONFIDENT

14. Rate your confidence in any alternative courses of treatment (exercise, diet, vitamin, acupuncture, massage, etc.)

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>
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NO CONFIDENCE VERY CONFIDENT

15. How well do you feel today? (answer with "0" only)

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>
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EXTREMELY POOR EXTREMELY WELL

**SECTION II: SIDE EFFECTS OF EXERCISE**

16. Have you gained weight?

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>
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NO CHANGE GAINED A LOT OF WEIGHT

17. Has your appetite increased?

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>
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NORMAL APPETITE

OVEREATING MORE

18. Do you feel stronger?

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>
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ABOUT THE SAME

MUCH STRONGER

19. Is your lung capacity improved (more endurance)?

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>
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ABOUT THE SAME

MUCH IMPROVED

SECTION III: SIDE EFFECTS OF MEDICATION

20. Do you lose weight after ingestion of medication?

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>
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ABOUT THE SAME

LOSE WEIGHT

21. Have you felt swollen, bloated, or edematous?

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>
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NOT BLOATED

EXTREMELY BLOATED

22. If yes to above, does this swelling, etc., disturb you?

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>
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NOT DISTRESSED

EXTREMELY DISTRESSED

SECTION IV: PROBLEMS IN DAILY ACTIVITIES

Sometimes having cancer may affect activities for daily living. For each of the items below, please rate how often this has happened to you while participating in the exercise program. If any situation has improved, estimate the percent improvement in the last column.

1. Need someone to help you travel around your community because of your health.

Never	Rarely	Sometimes	Frequently	All the Time	% Improvement
1	2	3	4	5	_____

2. Stay indoors most of the day because of your health.

Never	Rarely	Sometimes	Frequently	All the Time	% Improvement
1	2	3	4	5	_____

3. Not being able to do the kind of vigorous activities you used to, such as running, lifting heavy objects, or participating in sports, because of your health.

Never	Rarely	Sometimes	Frequently	All the Time	% Improvement
1	2	3	4	5	_____

4. Having trouble bending, lifting, or stooping, because of your health.

Never	Rarely	Sometimes	Frequently	All the Time	% Improvement
1	2	3	4	5	_____

5. Need help with eating, dressing, bathing, or using the toilet because of your health.

Never	Rarely	Sometimes	Frequently	All the Time	% Improvement
1	2	3	4	5	_____

6. Having trouble working at a job, doing housework, or school work because of your health.

Never	Rarely	Sometimes	Frequently	All the Time	% Improvement
1	2	3	4	5	_____

### SECTION V: PAIN RATING SCALE

Indicate the number that describes how pain has interfered with selected aspects of your life, using the same rating scale as in sections I-III.  
Key: "X"=pre exercise program, "O"=post-exercise program, 0=no change

1. General activity

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>
COMPLETELY INTERFERES				DOES NOT INTERFERE				

2. Mood

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>
COMPLETELY INTERFERES				DOES NOT INTERFERE				

3. Exercise ability

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>
COMPLETELY INTERFERES				DOES NOT INTERFERE				

4. Normal work (includes work both outside and inside the home)

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>
COMPLETELY INTERFERES				DOES NOT INTERFERE				

5. Relations with other people

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>
COMPLETELY INTERFERES				DOES NOT INTERFERE				

6. Sleep patterns

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>
COMPLETELY INTERFERES				DOES NOT INTERFERE				

7. Enjoyment of life

<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>5</b>	<b>6</b>	<b>7</b>	<b>8</b>	<b>9</b>
COMPLETELY INTERFERES				DOES NOT INTERFERE				

Are you a member of a support group? (or have you ever been?)

\_\_\_\_\_

Do you participate in regular meditation or relaxation? (list process):

\_\_\_\_\_

Amount of time spent per day/week in this process? \_\_\_\_\_