

**PROSTATE PATIENT FACTORS – FOLLOW-UP**

**Study Number**

RQ□□□□□-□

**Date of Birth** (dd/mm/yyyy)

□□/□□/□□□□

**Date Completed** (dd/mm/yyyy)

□□/□□/□□□□

**Name + Signature of Person completing the CRF**

\_\_\_\_\_

**Time Point**

- 1 year after RT start       3 years after RT start\*  
 2 years after RT start       4 years after RT start\*

\* if available

**Patient Information**

**Weight**  
(kg)

□□□

**Current smoker?**

0=No  
1=Yes, \_\_\_\_\_ [no. of] tobacco products a day  
7=Do not wish to answer

**Approximate number of alcoholic drinks a week**

□□□

777=Do not wish to answer

**Any newly diagnosed diseases since prostate cancer diagnosis?**

0=No  
1=Yes

**If yes,**

**Diabetes**

0=No  
 1=Yes

If yes, duration (months)

□□

**Rheumatoid Arthritis**

0=No  
 1=Yes

If yes, duration (months)

□□

**Systemic Lupus Erythematosus**

0=No  
 1=Yes

If yes, duration (months)

□□

**Other collagen vascular disease**

0=No  
 1=Yes

If yes, duration (months)

□□

**Hypertension**

0=No  
 1=Yes

If yes, duration (months)

□□

**Heart disease**

0=No  
 1=Yes

If yes, duration (months)

□□

**Any inflammatory bowel or diverticular disease**

0=No  
1=Crohn's disease  
2=Colitis ulcerosa  
3=Diverticulosis  
4=Other

If yes, duration (months)

□□

**Haemorrhoids**

0=No  
 1=Yes

If yes, duration (months)

□□

If yes, physician confirmed?

0=No  
 1=Yes

Depression	<input type="checkbox"/> 0=No <input type="checkbox"/> 1=Yes	If yes, duration (months)	<input type="checkbox"/> <input type="checkbox"/>
On ACE inhibitor?	<input type="checkbox"/> 0=No <input type="checkbox"/> 1=Yes	If yes, duration (months)	<input type="checkbox"/> <input type="checkbox"/>
On beta blocker?	<input type="checkbox"/> 0=No <input type="checkbox"/> 1=Yes	If yes, duration (months)	<input type="checkbox"/> <input type="checkbox"/>
On other anti-hypertensive drug?	<input type="checkbox"/> 0=No <input type="checkbox"/> 1=Yes	If yes, duration (months)	<input type="checkbox"/> <input type="checkbox"/>
On statin?	<input type="checkbox"/> 0=No <input type="checkbox"/> 1=Yes	If yes, duration (months)	<input type="checkbox"/> <input type="checkbox"/>
On other lipid-lowering drugs?	<input type="checkbox"/> 0=No <input type="checkbox"/> 1=Yes	If yes, duration (months)	<input type="checkbox"/> <input type="checkbox"/>
On anti-diabetic drug?	<input type="checkbox"/> 0=No <input type="checkbox"/> 1=Yes	If yes, duration (months)	<input type="checkbox"/> <input type="checkbox"/>
On phosphodiesterase type 5 (PDE5) inhibitor like cialis?	<input type="checkbox"/> 0=No <input type="checkbox"/> 1=Yes	If yes, duration (months)	<input type="checkbox"/> <input type="checkbox"/>
On sildenafil?	<input type="checkbox"/> 0=No <input type="checkbox"/> 1=Yes	If yes, duration (months)	<input type="checkbox"/> <input type="checkbox"/>
On 5 alpha-reductase inhibitor?	<input type="checkbox"/> 0=No <input type="checkbox"/> 1=Yes	If yes, duration (months)	<input type="checkbox"/> <input type="checkbox"/>
On alpha blocker?	<input type="checkbox"/> 0=No <input type="checkbox"/> 1=Yes	If yes, duration (months)	<input type="checkbox"/> <input type="checkbox"/>
On anti-muscarinic drugs?	<input type="checkbox"/> 0=No <input type="checkbox"/> 1=Yes	If yes, duration (months)	<input type="checkbox"/> <input type="checkbox"/>
On amiodarone?	<input type="checkbox"/> 0=No <input type="checkbox"/> 1=Yes	If yes, duration (months)	<input type="checkbox"/> <input type="checkbox"/>
On analgesics?	<input type="checkbox"/> 0=No <input type="checkbox"/> 1=Yes	If yes, duration (months)	<input type="checkbox"/> <input type="checkbox"/>
On antidepressant?	<input type="checkbox"/> 0=No <input type="checkbox"/> 1=Yes	If yes, duration (months)	<input type="checkbox"/> <input type="checkbox"/>
Hip replacement?	<input type="checkbox"/> 0=No <input type="checkbox"/> 1=Unilateral <input type="checkbox"/> 2=Bilateral	Previous abdominal surgery	<input type="checkbox"/> 0=No 1=Appendectomy 2=Cholecystectomy 3=Rectum-sigma resection 4=Nephrectomy 5=Other
Bladder TUR	<input type="checkbox"/> 0=No <input type="checkbox"/> 1=Yes		
Family history of prostate cancer in first degree relative	<input type="checkbox"/> 0=No <input type="checkbox"/> 1=Yes	Family history of radiotherapy toxicity	<input type="checkbox"/> 0=No 1=Yes 9=Not known

Other co-morbidity \_\_\_\_\_

Any newly diagnosed recurrence, metastasis or cancer since prostate cancer diagnosis?  0=No  
 1=Yes

**If yes,**

Site of loco-regional recurrence/progression or distant metastasis

- |                          |                          |               |                |
|--------------------------|--------------------------|---------------|----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 1=Biochemical | 6=Lung         |
|                          |                          | 2=Local       | 7=Liver        |
|                          |                          | 3=Pelvic      | 8=Brain        |
|                          |                          | 4=Lymph Nodes | 9=Other, _____ |
|                          |                          | 5=Bone        |                |
|                          |                          |               | 99=Not known   |

Type of new cancer

ICD-10 / ICD-O-3 coding: . /

Additional treatment following initial management

- |                          |                          |                    |                |
|--------------------------|--------------------------|--------------------|----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | 0=No               | 5=Chemotherapy |
|                          |                          | 1=Hormonal therapy | 6=Other, _____ |
|                          |                          | 2=Targeted therapy |                |
|                          |                          | 3=Surgery          |                |
|                          |                          | 4=Radiotherapy     | 99=Not known   |