

Data Collection Worksheet

Please Note: The Data Collection Worksheet (DCW) is a tool to aid investigators to integrate the collection of PhenX measures in your study. The PhenX measures that you selected and added to your Cart are presented in the DCW in alphabetical order. The DCW includes worksheets for data collection. Variables derived from the collected data are shown in the Data Dictionary (DD) with variable names and unique PhenX variable identifiers. The collection of DCWs produced by the Toolkit is not designed as a data collection instrument. Each investigator will decide how to integrate PhenX measures into data collection for their study.

1. Have you ever had cancer?
 Yes
 No

If so, please complete the following chart:

** Please include any diagnosis of Breast DCIS here, and specify Breast Cancer or DCIS.

Cancer Site/Type:	Example: Breast Cancer	Your Cancer:
Laterality (Left/Right/ Not Applicable)	Left	
Date of Diagnosis	12/2000	
Age of Diagnosis	47	
Did you have Surgery for this Cancer?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
If yes: Name of Procedure	Radical mastectomy (left)	
Surgery Date	1/5/2001	
Treatment Hospital	Jefferson, Philadelphia PA	
Did you receive Chemotherapy for this Cancer?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure

If yes: Type of Chemo* (Please choose from chemo drug list below)	Adriamycin® & Cytoxan®	
Date Chemo completed	2/2001	
Treatment Hospital	Jefferson, Philadelphia PA	
Did you receive Radiation for this Cancer?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
Date Radiation completed	3/2001	
Treatment Hospital	HUP	
Did you receive Hormonal Therapy for this Cancer?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
If yes: Name of Hormone Therapy (ex. Tamoxifen, Aromasin®, Femara®)	Tamoxifen	
Treatment Hospital	HUP	
Date Hormonal Therapy started	4/2001	
Did you receive any other type(s) of therapy?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
If yes: Please specify.		
Date Other Therapy started		
Treatment Hospital		
Have you had a Recurrence with this Cancer?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
If yes: Date of Recurrence?	9/2002	
Where did this cancer recur? (ex. lung, breast, liver)	Lung	

Treatment Hospital	HUP	
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If you have been diagnosed with more than one cancer, please complete the following chart:

Cancer Site/Type:	Example: Second Cancer: Breast Cancer	Your Second Cancer:
Laterality (Left/Right/ Not Applicable)	Right	
Date of Diagnosis	5/2003	
Age of Diagnosis	50	
Did you have Surgery for this Cancer?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
If yes: Name of Procedure	Radical mastectomy (right)	
Surgery Date	6/1/2003	
Treatment Hospital	Jefferson, Philadelphia PA	
Did you receive Chemotherapy for this Cancer?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
If yes: Type of Chemo* (Please choose from list below)	Adriamycin® & Cytosan®	
Date Chemo started	7/2003	
Treatment Hospital	Jefferson, Philadelphia PA	
Did you receive Radiation for this Cancer?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
Date Radiation started		
Treatment Hospital		
Did you receive Hormonal Therapy for this Cancer?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
If yes: Name of Hormone Therapy	Tamoxifen	

(ex. Tamoxifen, Aromasin®, Femara®)		
Treatment Hospital	HUP	
Date Hormonal Therapy started	8/2003	
Did you receive any other type(s) of therapy?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Not Sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
If yes: Please specify.		
Date Other Therapy started		
Treatment Hospital		
Have you had a Recurrence with this Cancer?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure
If yes: Date of Recurrence?	10/2004	
Where did this cancer recur? (ex. lung, breast, liver)	Chest Wall	
Treatment Hospital	HUP	

***Chemo Drug List Examples**

Adriamycin®

Paclitaxel Taxotere®

Cytosan®

Xeloda®

Other

Leucovorin®

Fluorouracil®

Methotrexate Taxol®

Herceptin®

Avastin®

Protocol source: <https://www.phenxtoolkit.org/protocols/view/71101#Source>