

**QUALITY OF LIFE QUESTIONNAIRE of the PORTEC-4a trial**



**EORTC QLQ-C30 (version 3)**

**Study number**

We are interested in some things about you and your health. Please answer all of the questions yourself by circling the number that best applies to you. There are no "right" or "wrong" answers. The information that you provide will remain strictly confidential.

Today's date (Day, Month, Year):

	<b>Not at All</b>	<b>A Little</b>	<b>Quite a Bit</b>	<b>Very Much</b>
1. Do you have any trouble doing strenuous activities, like carrying a heavy shopping bag or a suitcase?	1	2	3	4
2. Do you have any trouble taking a <u>long</u> walk?	1	2	3	4
3. Do you have any trouble taking a <u>short</u> walk outside of the house?	1	2	3	4
4. Do you need to stay in bed or a chair during the day?	1	2	3	4
5. Do you need help with eating, dressing, washing yourself or using the toilet?	1	2	3	4

<b>During the past week:</b>	<b>Not at All</b>	<b>A Little</b>	<b>Quite a Bit</b>	<b>Very Much</b>
6. Were you limited in doing either your work or other daily activities?	1	2	3	4
7. Were you limited in pursuing your hobbies or other leisure time activities?	1	2	3	4
8. Were you short of breath?	1	2	3	4
9. Have you had pain?	1	2	3	4
10. Did you need to rest?	1	2	3	4
11. Have you had trouble sleeping?	1	2	3	4
12. Have you felt weak?	1	2	3	4
13. Have you lacked appetite?	1	2	3	4
14. Have you felt nauseated?	1	2	3	4
15. Have you vomited?	1	2	3	4

Please go on to the next page

<b>During the past week:</b>	<b>Not at All</b>	<b>A Little</b>	<b>Quite a Bit</b>	<b>Very Much</b>
16. Have you been constipated?	1	2	3	4
17. Have you had diarrhea?	1	2	3	4
18. Were you tired?	1	2	3	4
19. Did pain interfere with your daily activities?	1	2	3	4
20. Have you had difficulty in concentrating on things, like reading a newspaper or watching television?	1	2	3	4
21. Did you feel tense?	1	2	3	4
22. Did you worry?	1	2	3	4
23. Did you feel irritable?	1	2	3	4
24. Did you feel depressed?	1	2	3	4
25. Have you had difficulty remembering things?	1	2	3	4
26. Has your physical condition or medical treatment interfered with your <u>family</u> life?	1	2	3	4
27. Has your physical condition or medical treatment interfered with your <u>social</u> activities?	1	2	3	4
28. Has your physical condition or medical treatment caused you financial difficulties?	1	2	3	4

**For the following questions please circle the number between 1 and 7 that best applies to you:**

29. How would you rate your overall health during the past week?

1            2            3            4            5            6            7

Very poor

Excellent

30. How would you rate your overall quality of life during the past week?

1            2            3            4            5            6            7

Very poor

Excellent



**EORTC QLQ – EN24**

**Study Number:**

Patients sometimes report that they have the following symptoms or problems. Please indicate the extent to which you have experienced these symptoms or problems.

<b>During the past week:</b>	<b>Not at all</b>	<b>A little</b>	<b>Quite a bit</b>	<b>Very Much</b>
31. Have you had swelling in one or both legs?	1	2	3	4
32. Have you felt heaviness in one or both legs?	1	2	3	4
33. Have you had pain in your lower back and / or pelvis?	1	2	3	4
34. When you felt the urge to pass urine, did you have to hurry to get to the toilet?	1	2	3	4
35. Have you passed urine frequently?	1	2	3	4
36. Have you had leaking of urine?	1	2	3	4
37. Have you had pain or a burning feeling when passing urine?	1	2	3	4
38. When you felt the urge to move your bowels, did you have to hurry to get to the toilet?	1	2	3	4
39. Have you had any leakage of stools?	1	2	3	4
40. Have you been troubled by passing wind?	1	2	3	4
41. Have you had cramps in your abdomen?	1	2	3	4
42. Have you had a bloated feeling in your abdomen?	1	2	3	4
43. Have you had tingling or numbness in your hands or feet?	1	2	3	4
44. Have you had aches or pains in your muscles or joints?	1	2	3	4
45. Have you lost hair?	1	2	3	4
46. Has food and drink tasted differently from usual?	1	2	3	4
47. Have you felt physically less attractive as a result of your disease or treatment?	1	2	3	4

Please go on to the next page

<b>During the past week:</b>		<b>Not at all</b>	<b>A little</b>	<b>Quite a bit</b>	<b>Very Much</b>
48.	Have you felt less feminine as a result of your disease or treatment?	1	2	3	4

49. Do you currently have a partner?    Yes      No  

<b>During the past 3 months:</b>		<b>Not at all</b>	<b>A little</b>	<b>Quite a bit</b>	<b>Very Much</b>
50.	To what extent were you interested in sex?	1	2	3	4
51.	To what extent were you sexually active?	1	2	3	4
52.	If you have not been sexually active, please provide the reason: <input type="checkbox"/> I do not have a partner (anymore) <input type="checkbox"/> In our relationship sexuality is not important (anymore) <input type="checkbox"/> Medical reasons of my partner <input type="checkbox"/> Due to my illness / treatment				

**Please answer these questions only if you have been sexually active during the past 3 months:**

53.	Has your vagina felt dry during sexual activity?	1	2	3	4
54.	Has your vagina felt short and / or tight?	1	2	3	4
55.	Have you had pain during sexual intercourse or other sexual activity?	1	2	3	4
56.	Was sexual activity enjoyable for you?	1	2	3	4