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

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.

Please fill in your first initial: |____|
Your birth date (Day, Month, Year): |__|__||__|__||__|__|__|__|
Today's date (Day, Month, Year): |__|__||__|__||__|__|__|__|

		Not at All	A Little	Quite a Bit	Very Much
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 long walk?	1	2	3	4
3.	Do you have any trouble taking a short 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

During the past week:

		Not at All	A Little	Quite a Bit	Very Much
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

During the past week:	**Not at All**	**A Little**	**Quite a Bit**	**Very Much**
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 family life?	1	2	3	4
27. Has your physical condition or medical treatment interfered with your social 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 – CX24

Patients sometimes report that they have the following symptoms or problems. Please indicate the extent to which you have experienced these symptoms or problems, please answer by circling the number that best applies to you.

During the past week:		**Not at all**	**A little**	**Quite a bit**	**Very much**
31.	Have you had cramps in your abdomen?	1	2	3	4
32.	Have you had difficulty in controlling your bowels?	1	2	3	4
33.	Have you had blood in your stools (motions)?	1	2	3	4
34.	Did you pass water/urine frequently?	1	2	3	4
35.	Have you had pain or a burning feeling when passing water/urinating?	1	2	3	4
36.	Have you had leaking of urine?	1	2	3	4
37.	Have you had difficulty emptying your bladder?	1	2	3	4
38.	Have you had swelling in one or both legs?	1	2	3	4
39.	Have you had pain in your lower back?	1	2	3	4
40.	Have you had tingling or numbness in your hands or feet?	1	2	3	4
41.	Have you had irritation or soreness in your vagina or vulva?	1	2	3	4
42.	Have you had discharge from your vagina?	1	2	3	4
43.	Have you had abnormal bleeding from your vagina?	1	2	3	4
44.	Have you had hot flushes and/or sweats?	1	2	3	4
45.	Have you felt physically less attractive as a result of your disease or treatment?	1	2	3	4
46.	Have you felt less feminine as a result of your disease or treatment?	1	2	3	4
47.	Have you felt dissatisfied with your body?	1	2	3	4

Please go on to the next page

During the past 4 weeks:		**Not at all**	**A little**	**Quite a bit**	**Very much**
48.	Have you worried that sex would be painful?	1	2	3	4
49.	Have you been sexually active?	1	2	3	4

Answer these questions only if you have been sexually active during the past <u>4 weeks</u>:		**Not at all**	**A little**	**Quite a bit**	**Very much**
50.	Has your vagina felt dry during sexual activity?	1	2	3	4
51.	Has your vagina felt short?	1	2	3	4
52.	Has your vagina felt tight?	1	2	3	4
53.	Have you had pain during sexual intercourse or other sexual activity?	1	2	3	4
54.	Was sexual activity enjoyable for you?	1	2	3	4

<u>EORTC QLQ - OV28 (subscale)</u>

During the past week:		**Not at All**	**A Little**	**Quite a Bit**	**Very Much**
55.	Did you have a bloated feeling in your abdomen / stomach?	1	2	3	4
56.	Were you troubled by passing wind / gas / flatulence?	1	2	3	4
57.	Have you lost any hair?	1	2	3	4
58.	Answer this question only if you had any hair loss: Were you upset by the loss of your hair?	1	2	3	4
59.	Did food and drink taste different from usual?	1	2	3	4
60.	Have you had tingling hands or feet?	1	2	3	4
61.	Have you had numbness in your fingers or toes?	1	2	3	4
62.	Have you felt weak in your arms or legs?	1	2	3	4
63.	Did you have aches or pains in your muscles or joints?	1	2	3	4
64.	Did you have problems with hearing?	1	2	3	4