MRN:	
Today's Date:	

EORTC QLQ-C30

Patient details

Surname:		**First name:**		**DOB:**

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

Mobility	**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
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

Physical functioning **During the past week:**	**Not at all**	**A little**	**Quite a bit**	**Very much**
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
16. Have you been constipated?	1	2	3	4
17. Have you had diarrhoea?	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 tingling in your hands or feet?	1	2	3	4

Emotional wellbeing	Not at all	A little	Quite a bit	Very much
21. Have you had difficulty in concentrating on things, like reading a newspaper or watching television	1	2	3	4
22. Did you feel tense?	1	2	3	4
23. Did you worry?	1	2	3	4
24. Did you feel irritable?	1	2	3	4
25. Did you feel depressed?	1	2	3	4
26. Have you had difficulty remembering things?	1	2	3	4

Social and economic During the past week:	Not at all	A little	Quite a bit	Very much
27. Has your physical condition or medical treatment interfered with your family life?	1	2	3	4
28. Has your physical condition or medical treatment interfered with your social activities?	1	2	3	4
29. 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

30. How would you rate your overall <u>health</u> during the past week?

1 2 3 4 5 6 7

Very poor **Excellent**

31. How would you rate your overall <u>quality of life</u> during the past week?

1 2 3 4 5 6 7

Very poor **Excellent**

EORTC QLQ-CR29

Surname:		First name:		DOB:	

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

Symptoms and problems **During the past week:**	**Not at all**	**A little**	**Quite a bit**	**Very much**
32. Did you urinate frequently during the day?	1	2	3	4
33. Did you urinate frequently during the night?	1	2	3	4
34. Have you had any unintentional release (leakage) of urine?	1	2	3	4
35. Did you have any pain when you urinated?	1	2	3	4
36. Did you have abdominal pain?	1	2	3	4
37. Did you have any pain in your buttocks/anal area/rectum?	1	2	3	4
38. Did you have a bloated feeling in your abdomen?	1	2	3	4
39. Have you had blood in your stools?	1	2	3	4
40. Have you had mucus in your stools?	1	2	3	4

During the past week:	**Not at all**	**A little**	**Quite a bit**	**Very much**
41. Did you have a dry mouth?	1	2	3	4
42. Have you lost your hair as a result of your treatment?	1	2	3	4
43. Have you had problems with your sense of taste?	1	2	3	4
44. Were you worried about your health in the future?	1	2	3	4
45. Have you worried about your weight?	1	2	3	4
46. Have you felt physically less attractive as a result of your disease or treatment?	1	2	3	4
47. Have you been feeling less feminine/masculine as a result of your disease or treatment?	1	2	3	4
48. Have you been dissatisfied with your body?	1	2	3	4

49. Do you have a stoma bag (colostomy/ileostomy)? Yes No

Answer these question ONLY IF YOU HAVE A STOMA BAG **During the past week:**	**Not at all**	**A little**	**Quite a bit**	**Very much**
50. Have you had unintentional release of gas/flatulence from your stoma bag?	1	2	3	4
51. Have you had leakage of stools from your stoma bag?	1	2	3	4
52. Have you had sore skin around your stoma?	1	2	3	4
53. Did frequent bag changes occur during the day?	1	2	3	4
54. Did frequent bag changes occur during the night?	1	2	3	4
55. Did you feel embarrassed because of your stoma?	1	2	3	4
56. Did you have problems caring for your stoma?	1	2	3	4

Answer these question ONLY IF YOU DO NOT HAVE A STOMA BAG	**Not at all**	**A little**	**Quite a bit**	**Very much**
50. Have you had unintentional release of gas/flatulence from your back passage?	1	2	3	4
51. Have you had leakage of stools from your back passage?	1	2	3	4
52. Have you had sore skin around your anal area?	1	2	3	4
53. Did frequent bowl movements occur during the day?	1	2	3	4
54. Did frequent bowl movements occur during the night?	1	2	3	4
55. Did you feel embarrassed because of your bowel movement?	1	2	3	4

During the past 4 weeks:

For men only	**Not at all**	**A little**	**Quite a bit**	**Very much**
57. To what extent were you interested in sex?	1	2	3	4
58. Did you have difficulty getting or maintaining an erection?	1	2	3	4

For women only	**Not at all**	**A little**	**Quite a bit**	**Very much**
59. To what extent were you interested in sex?	1	2	3	4
60. Did you have pain or discomfort during intercourse?	1	2	3	4