Below is a list of statements that other people with your illness have said are important. **Please circle or mark one number per line to indicate your response as it applies to the past 7 days.**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  | **Not at all** | **A little bit** | **Somewhat** | **Quite a bit** | **Very much** |
|  |
|  |
|  |  |  |  |  |  |  |
| H&N2 | My mouth is dry | 0 | 1 | 2 | 3 | 4 |
| ST16 | My eyes are dry | 0 | 1 | 2 | 3 | 4 |
| P7 | I have difficulty urinating | 0 | 1 | 2 | 3 | 4 |
| GP2 | I have nausea | 0 | 1 | 2 | 3 | 4 |
| O2 | I have been vomiting | 0 | 1 | 2 | 3 | 4 |
| C5 | I have diarrhea (diarrhoea) | 0 | 1 | 2 | 3 | 4 |
| Pal5 | I am constipated | 0 | 1 | 2 | 3 | 4 |
| Ga1 | I have a loss of appetite | 0 | 1 | 2 | 3 | 4 |
| HI7 | I feel fatigued | 0 | 1 | 2 | 3 | 4 |
| AA1 | My fatigue keeps me from doing the things I want to do | 0 | 1 | 2 | 3 | 4 |
| GP4 | I have pain | 0 | 1 | 2 | 3 | 4 |
| BP1 | I have bone pain | 0 | 1 | 2 | 3 | 4 |
| P3 | My pain keeps me from doing things I want to do | 0 | 1 | 2 | 3 | 4 |
| GP5 | I am bothered by side effects of treatment | 0 | 1 | 2 | 3 | 4 |
| Leu7 | I feel isolated from others because of my illness or treatment | 0 | 1 | 2 | 3 | 4 |