Measure of Ovarian cancer Symptoms and Treatment concerns - Surveillance (MOST-S26)

Patient's initials: | | | | Study no. | | | | | | | Current date: | | D D | | M M | | Y Y |

Please **circle** one number for each line to best show **how much that aspect troubled you** on average **during the last 3 to 4 weeks**.

	No trouble at all		Mild			Moderate			Severe		Worst I can imagine
1. Fatigue (tiredness)	0	1	2	3	4	5	6	7	8	9	10
2. Poor appetite (or feeling full quickly)	0	1	2	3	4	5	6	7	8	9	10
3. Abdominal pain, discomfort and/or cramps	0	1	2	3	4	5	6	7	8	9	10
4. Abdominal swelling, bloating and/or fullness	0	1	2	3	4	5	6	7	8	9	10
5. Nausea	0	1	2	3	4	5	6	7	8	9	10
6. Vomiting	0	1	2	3	4	5	6	7	8	9	10
7. Constipation	0	1	2	3	4	5	6	7	8	9	10
8. Shortness of breath	0	1	2	3	4	5	6	7	8	9	10
9. Leg swelling	0	1	2	3	4	5	6	7	8	9	10
10. Trouble sleeping	0	1	2	3	4	5	6	7	8	9	10
11. Numbness or pins and needles	0	1	2	3	4	5	6	7	8	9	10
12. Sore hands and feet	0	1	2	3	4	5	6	7	8	9	10
13. Trouble concentrating	0	1	2	3	4	5	6	7	8	9	10
14. Anxiety (feeling worried)	0	1	2	3	4	5	6	7	8	9	10
15. Depression (feeling sad)	0	1	2	3	4	5	6	7	8	9	10
16. Problems doing what I wanted	0	1	2	3	4	5	6	7	8	9	10

Please circle one number for each line to show how you would have rated yourself on that aspect on average during **the last 3 to 4 weeks**.

	Best possible		Very good		Good		Fair		Poor		Very poor	Worst possible
17. Physical well-being	10	9	8	7	6	5	4	3	2	1		0
18. Emotional well-being	10	9	8	7	6	5	4	3	2	1		0
19. Overall well-being	10	9	8	7	6	5	4	3	2	1		0

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20. Are you currently having any treatment prescribed by your oncologist including tablets or infusions?	Yes	No
	If **yes**, please answer questions 21-24	If **no**, please skip questions 21-24

Please **circle** one number for each line to best show **how much that aspect troubled you** on average **during the last 3 to 4 weeks**.

	No trouble at all		Mild			Moderate			Severe		Worst I can imagine
21. Problems taking tablets	0	1	2	3	4	5	6	7	8	9	10
22. Problems with needles or injections	0	1	2	3	4	5	6	7	8	9	10
23. Inconvenience of treatment	0	1	2	3	4	5	6	7	8	9	10
24. Thought of actually having treatment	0	1	2	3	4	5	6	7	8	9	10

25. Do you have any other symptoms that are bothering you? Yes No

26. **What are those symptoms?** Please list up to three symptoms that are troubling you, and **circle** the number that best represents **how much each symptom has troubled you** on average **during the last 3 to 4 weeks**.

	No trouble at all		Mild			Moderate			Severe		Worst I can imagine
1. _____	0	1	2	3	4	5	6	7	8	9	10
2. _____	0	1	2	3	4	5	6	7	8	9	10
3.	0	1	2	3	4	5	6	7	8	9	10

Thank you for completing this questionnaire