Measure of Ovarian cancer Symptoms and Treatment concerns - MOST-T35 (MOST v1)

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.	Pain (all and anywhere)	0	1	2	3	4	5	6	7	8	9	10
2.	Fatigue (tiredness)	0	1	2	3	4	5	6	7	8	9	10
3.	Poor appetite (or feeling full quickly)	0	1	2	3	4	5	6	7	8	9	10
4.	Abdominal pain, discomfort and/or cramps	0	1	2	3	4	5	6	7	8	9	10
5.	Abdominal swelling, bloating and/or fullness	0	1	2	3	4	5	6	7	8	9	10
6.	Trouble eating	0	1	2	3	4	5	6	7	8	9	10
7.	Indigestion	0	1	2	3	4	5	6	7	8	9	10
8.	Nausea	0	1	2	3	4	5	6	7	8	9	10
9.	Vomiting	0	1	2	3	4	5	6	7	8	9	10
10.	Diarrhoea	0	1	2	3	4	5	6	7	8	9	10
11.	Constipation	0	1	2	3	4	5	6	7	8	9	10
12.	Bladder problems	0	1	2	3	4	5	6	7	8	9	10
13.	Shortness of breath	0	1	2	3	4	5	6	7	8	9	10
14.	Leg swelling	0	1	2	3	4	5	6	7	8	9	10
15.	Trouble sleeping	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
16.	Physical well-being	10	9	8	7	6	5	4	3	2	1	0
17.	Emotional well-being	10	9	8	7	6	5	4	3	2	1	0
18.	Overall well-being	10	9	8	7	6	5	4	3	2	1	0

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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
19. Altered sense of taste	0	1	2	3	4	5	6	7	8	9	10
20. Sore mouth or throat	0	1	2	3	4	5	6	7	8	9	10
21. Difficulty swallowing	0	1	2	3	4	5	6	7	8	9	10
22. Loss of appetite	0	1	2	3	4	5	6	7	8	9	10
23. Hair loss	0	1	2	3	4	5	6	7	8	9	10
24. Skin rash	0	1	2	3	4	5	6	7	8	9	10
25. Numbness or pins and needles	0	1	2	3	4	5	6	7	8	9	10
26. Sore hands and feet	0	1	2	3	4	5	6	7	8	9	10
27. Problems taking tablets	0	1	2	3	4	5	6	7	8	9	10
28. Problems with needles or Injections	0	1	2	3	4	5	6	7	8	9	10
29. Inconvenience of treatment	0	1	2	3	4	5	6	7	8	9	10
30. Thought of actually having treatment	0	1	2	3	4	5	6	7	8	9	10
31. Trouble concentrating	0	1	2	3	4	5	6	7	8	9	10
32. Anxiety (feeling worried)	0	1	2	3	4	5	6	7	8	9	10
33. Depression (feeling sad)	0	1	2	3	4	5	6	7	8	9	10
34. Problems doing what I wanted	0	1	2	3	4	5	6	7	8	9	10
35. Problems for my family or friends	0	1	2	3	4	5	6	7	8	9	10

Thank you for completing this questionnaire