Quality of Life – Esophageal Cancer

REGISTRY ID:													FORM CODE: FAEA VERSION:A 04/12/11	Event			SEQ #		

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

Instructions: Enter the answer given by the participant for each response.

*We have just a few more questions to ask you. The next questions I am going to ask you are about problems that you may or may not have experienced over the **past 7 days**. I will read you a statement and would like you to tell me how this applies to you by answering not at all, a little bit, somewhat, quite a bit, or very much. Please remember when answering, we are interested in the **past 7 days**.*

During the past 7 days,….

	Not at all	A little bit	Somewhat	Quite a bit	Very much
1. You were able to eat the foods that you like……	☐	☐	☐	☐	☐
2. Your mouth was dry.	☐	☐	☐	☐	☐
3. You had trouble breathing.....	☐	☐	☐	☐	☐
4. Your voice had its usual quality and strength.	☐	☐	☐	☐	☐
5. You were able to eat as much food as you wanted	☐	☐	☐	☐	☐
6. You were able to communicate with others.....	☐	☐	☐	☐	☐
7. You could swallow naturally and easily.	☐	☐	☐	☐	☐
8. You had difficulty swallowing solid foods.....	☐	☐	☐	☐	☐
9. You had difficulty swallowing soft or mashed foods.....	☐	☐	☐	☐	☐

During the past 7 days,….

	Not at all	A little bit	Somewhat	Quite a bit	Very much
10. You had difficulty swallowing liquids	☐	☐	☐	☐	☐
11. You had pain in your chest when you swallowed	☐	☐	☐	☐	☐
12. You choked when you swallowed	☐	☐	☐	☐	☐
13. You were able to enjoy meals with family or friends	☐	☐	☐	☐	☐
14. You had a good appetite.	☐	☐	☐	☐	☐
15. You woke up at night because of coughing.	☐	☐	☐	☐	☐
16. You had pain in your stomach area	☐	☐	☐	☐	☐
17. You were losing weight	☐	☐	☐	☐	☐

Esophageal Cancer Symptoms

REGISTRY ID:													FORM CODE: EOEA VERSION:A 04/12/11	Event			SEQ #		

ADMINISTRATIVE INFORMATION

0a. Completion Date: ☐☐/☐☐/☐☐☐☐ 0b. Staff ID: ☐☐☐

Instructions: Enter the answer given by the participant for each response by marking one box per row.

*Now, I will ask you about symptoms you may be experiencing. Please, for all symptoms, indicate to what extent you have been bothered by it using the responses not at all, a little, quite a bit, or very much. Please remember when answering, we are interested in the **past week**.*

	Not at all	A little	Quite a bit	Very much
1. Have you had trouble with swallowing your saliva?.....	☐	☐	☐	☐
2. Have you felt full too quickly?.....	☐	☐	☐	☐
3. Have you had trouble with eating?.....	☐	☐	☐	☐
4. Have you had trouble with eating in front of other people?..	☐	☐	☐	☐
5. Have you had problems with your sense of taste?.....	☐	☐	☐	☐
6. Have you had trouble with talking?.....	☐	☐	☐	☐
7. Have you had trouble with acid or bile coming into your mouth?.....	☐	☐	☐	☐
8. Have you had pain when you eat?.....	☐	☐	☐	☐
9. Have you had pain in your chest?.....	☐	☐	☐	☐