

Quality of Life – Bladder Cancer

REGISTRY ID:	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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FORM CODE: FABA
VERSION: A 12/08/11

Event

<input type="text"/>	<input type="text"/>
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SEQ #

<input type="text"/>	<input type="text"/>
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ADMINISTRATIVE INFORMATION

0a. Completion Date:

<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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0b. Staff ID:

<input type="text"/>	<input type="text"/>	<input type="text"/>
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Instructions: Enter the answer given by the participant for each response.

*The next questions I am going to ask you are about bladder and bowel 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**.*

- | | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. You had trouble controlling your urine..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Not at all | A little bit | Somewhat | Quite a bit | Very much |
| 2. You were losing weight..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Not at all | A little bit | Somewhat | Quite a bit | Very much |
| 3. You had control of your bowels..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Not at all | A little bit | Somewhat | Quite a bit | Very much |
| 4. You urinated more frequently than usual. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Not at all | A little bit | Somewhat | Quite a bit | Very much |
| 5. You had diarrhea | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Not at all | A little bit | Somewhat | Quite a bit | Very much |
| 6. You had a good appetite..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Not at all | A little bit | Somewhat | Quite a bit | Very much |
| 7. You liked the appearance of your body..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Not at all | A little bit | Somewhat | Quite a bit | Very much |
| 8. It burned when you urinated..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Not at all | A little bit | Somewhat | Quite a bit | Very much |
| 9. You were interested in sex..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Not at all | A little bit | Somewhat | Quite a bit | Very much |

For men only (women skip to question 11):

- | | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 10. You were able to have and maintain an erection | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Not at all | A little bit | Somewhat | Quite a bit | Very much |

11. Do you have an ostomy appliance?☐ Yes ☐ No → Skip to next form

12. You were embarrassed by your ostomy appliance☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

13. Caring for your ostomy appliance was difficult ...☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much