

CRC Cancer Symptoms

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"/>
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FORM CODE: EORA
VERSION:A 02/14/11

Event	<input type="text"/>	<input type="text"/>	SEQ #	<input type="text"/>	<input type="text"/>
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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 both 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**.

1. Did you have pain with your bowel movements?

☐Not at all☐A little☐Quite a bit☐Very much
2. Have you had blood in your stools?

☐Not at all☐A little bit☐Quite a bit☐Very much

Quality of Life – Colon 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: FACA
VERSION:A 06/14/11

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.

*We have just a few more questions to ask you about some symptoms you may have experienced during 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,....

- | | | | | | |
|--|--------------------------|--------------------------------------|--------------------------|--------------------------|--------------------------|
| 1. You had swelling or cramps in your stomach area. | <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 could digest your food well. | <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 (diarrhoea). | <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. Do you have an ostomy appliance? | <input type="checkbox"/> | <input type="checkbox"/> → Next Form | | | |
| | Yes | No | | | |
| 9. You were embarrassed by your ostomy appliance. | <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 |
| 10. Caring for your ostomy appliance was difficult. .. | <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 |

CRC Bowel Function

FORM CODE: FAIA
VERSION:A 06/14/11

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ADMINISTRATIVE INFORMATION

0a. Completion Date: / /

0b. Staff ID:			
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Instructions: Enter the answer given by the participant for each response by marking one box per row.

During the past 7 days,....

- | | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. You had to move your bowels 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 |
| 2. You were afraid to be far from a toilet..... | <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 to move your bowels frequently to avoid accidents..... | <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 could be far from home/work without fearing soilage... | <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 wore protection for soiling of stool..... | <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 were comfortable discussing your bowel problems with friends..... | <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 limited your social activity because of your bowel problems..... | <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. You limited your physical activity because of bowel problems..... | <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 limited your sexual activity because of your bowel problems.....	<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
10. You were embarrassed by your bowel problems.....	<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. Your bowel problems woke or kept you up at night.....	<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