

Quality of Life – Esophageal Cancer

FORM CODE: FAEA
VERSION:A 04/12/11

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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,....

- | | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. You were able to eat the foods that you like..... | <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. Your mouth was dry..... | <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 trouble breathing..... | <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. Your voice had its usual quality and strength. | <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 were able to eat as much food as you wanted | <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 able to communicate with others..... | <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 could swallow naturally and easily. | <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 had difficulty swallowing solid foods..... | <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 had difficulty swallowing soft or mashed foods..... | <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 |

During the past 7 days,....

- | | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 10. You had difficulty swallowing liquids | <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. You had pain in your chest when you
swallowed..... | <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 |
| 12. You choked when you swallowed | <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 |
| 13. You were able to enjoy meals with family or
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 |
| 14. 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 |
| 15. You woke up at night because of
coughing..... | <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 |
| 16. You had pain 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 |
| 17. 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 |

Esophageal 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: EOE
VERSION: A 04/12/11

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: //

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**.

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