

Quality of Life – Ovarian Cancer

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FORM CODE: FOV
VERSION:A 06/21/12

Event

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ADMINISTRATIVE INFORMATION

0a. Completion Date:

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0b. Staff ID:

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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 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 swelling 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 had been vomiting..... | <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 bothered by hair loss..... | <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. You were able to get around by yourself..... | <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 able to feel like a woman..... | <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 had 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 |
| 11. 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 |
| 12. You had concerns about your ability to have children..... | <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 bothered by swelling/fluid in your legs. ☐ ☐ ☐ ☐ ☐
Not at all A little bit Somewhat Quite a bit Very much
14. You were bothered by discomfort in your groin or legs. ☐ ☐ ☐ ☐ ☐
Not at all A little bit Somewhat Quite a bit Very much
15. You were bothered by wearing compression stockings. ☐ ☐ ☐ ☐ ☐
Not at all A little bit Somewhat Quite a bit Very much

Menopause

| | | | | | | | | | | | | | |
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FORM CODE: MRS
VERSION:A 02/07/12

Event

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| <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.

0c. Check the cancer-specific questionnaire where the MRS/MENQOL questions are answered.

- ☐ 0c1. Breast
☐ 0c2. Ovarian
☐ 0c3. Endometrial

The next questions I am going to ask you are about symptoms that you may or may not be experiencing. I will read you a symptom and would like you to tell me how this affects you by answering none, mild, moderate, severe, or extremely severe.

MRS

- | | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Hot flashes, sweating (episodes of sweating) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | None | Mild | Moderate | Severe | Extremely Severe |
| 2. Heart discomfort (unusual awareness of heart beat, heart skipping, heart racing, tightness) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | None | Mild | Moderate | Severe | Extremely Severe |
| 3. Sleep problems (difficulty in falling asleep, difficulty in sleeping through the night, waking up early) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | None | Mild | Moderate | Severe | Extremely Severe |
| 4. Depressive mood (feeling down, sad, on the verge of tears, lack of drive, mood swings) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | None | Mild | Moderate | Severe | Extremely Severe |
| 5. Irritability (feeling nervous, inner tension, feeling aggressive) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | None | Mild | Moderate | Severe | Extremely Severe |
| 6. Anxiety (inner restlessness, feeling panicky) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | None | Mild | Moderate | Severe | Extremely Severe |

| | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 7. Physical and mental exhaustion (general decrease in performance, impaired memory, decrease in concentration, forgetfulness) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | None | Mild | Moderate | Severe | Extremely Severe |
| 8. Sexual problems (change in sexual desire, in sexual activity and satisfaction) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | None | Mild | Moderate | Severe | Extremely Severe |
| 9. Bladder problems (difficulty in urinating, increased need to urinate, bladder incontinence). | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | None | Mild | Moderate | Severe | Extremely Severe |
| 10. Dryness of vagina (sensation of dryness or burning in the vagina, difficulty with sexual intercourse) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | None | Mild | Moderate | Severe | Extremely Severe |
| 11. Joint and muscular discomfort (pain in the joints, rheumatoid complaints) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | None | Mild | Moderate | Severe | Extremely Severe |

MENQOL

| | | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 12. Flatulence (wind) or gas pains | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | None | Mild | Moderate | Severe | Extremely Severe |
| 13. Decrease in physical strength | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | None | Mild | Moderate | Severe | Extremely Severe |
| 14. Decrease in stamina | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | None | Mild | Moderate | Severe | Extremely Severe |
| 15. Drying skin..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | None | Mild | Moderate | Severe | Extremely Severe |
| 16. Increased facial hair..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | None | Mild | Moderate | Severe | Extremely Severe |
| 17. Changes in appearance, texture or tone of your skin | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | None | Mild | Moderate | Severe | Extremely Severe |
| 18. Feeling bloated | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | None | Mild | Moderate | Severe | Extremely Severe |

Urinary Symptoms

| | | | | | | | | | | | | | | | | | | | |
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FORM CODE: ICI
VERSION:A 06/22/12

Event

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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.

0c. Check the cancer-specific questionnaire where the ICIQ-FLUTS questions are answered.

- ☐ 0c1. Ovarian
☐ 0c2. Endometrial

Many people experience urinary symptoms some of the time. We are trying to find out how many people experience urinary symptoms, and how much they bother them. We would be grateful if you could answer the following questions, thinking about how you have been, on the average, over the PAST FOUR WEEKS.

1a. During the night, how many times did you have to get up to

urinate, on the average? A-E

- None A → Skip to Item 2a
One B
Two C
Three D
Four or more E

1b. How much did this bother you?

Please choose a number between 0 (not at all) and 10 (a great deal).

| Not at all | | | | | | | | | | | | A great deal | |
|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|--|
| <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"/> | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | | | |

2a. Did you have a sudden need to rush to the toilet to urinate?..... A-E

- Never A → Skip to Item 3a
Occasionally B
Sometimes C
Most of the time D
All of the time E

2b. How much did this bother you?

Please choose a number between 0 (not at all) and 10 (a great deal).

| Not at all | | | | | | | | | | | | A great deal | |
|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|----------------------|--|
| <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"/> | |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | | | |

- 3a. Did you have pain in your bladder? ☐ A-E
- Never A →Skip to Item 4a
- Occasionally B
- Sometimes C
- Most of the time D
- All of the time E

- 3b. How much did this bother you?
Please choose a number between 0 (not at all) and 10 (a great deal).
- | | Not at
all | | | | | | | | | A great
deal | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|----|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

- 4a. How often did you pass urine during the day? ☐ A-E
- 1-6 times A
- 7-8 times B
- 9-10 times C
- 11-12 times D
- 13 or more times E

- 4b. How much did this bother you?
Please choose a number between 0 (not at all) and 10 (a great deal).
- | | Not at
all | | | | | | | | | A great
deal | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|----|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

- 5a. Was there a delay before you could start to urinate? ☐ A-E
- Never A →Skip to Item 6a
- Occasionally B
- Sometimes C
- Most of the time D
- All of the time E

- 5b. How much did this bother you?
Please choose a number between 0 (not at all) and 10 (a great deal).
- | | Not at
all | | | | | | | | | A great
deal | |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|----|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | |
| | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

- 6a. Did you have to strain to urinate? ☐ A-E
- Never A →Skip to Item 7a
- Occasionally B
- Sometimes..... C
- Most of the time D
- All of the time E

- 6b. How much did this bother you?
Please choose a number between 0 (not at all) and 10 (a great deal).
- | Not at all | | | | | | | | | | | A great deal |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |

- 7a. Did you stop and start more than once while you urinated? ☐ A-E
- Never A →Skip to Item 8a
- Occasionally B
- Sometimes..... C
- Most of the time D
- All of the time E

- 7b. How much did this bother you?
Please choose a number between 0 (not at all) and 10 (a great deal).
- | Not at all | | | | | | | | | | | A great deal |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |

- 8a. Did urine leak before you could get to the toilet? ☐ A-E
- Never A →Skip to Item 9a
- Occasionally B
- Sometimes..... C
- Most of the time D
- All of the time E

- 8b. How much did this bother you?
Please choose a number between 0 (not at all) and 10 (a great deal).
- | Not at all | | | | | | | | | | | A great deal |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |

9a. How often did you leak urine? ☐ A-E

Never A →Skip to Next Form

Occasionally B

Sometimes..... C

Most of the time D

All of the time E

9b. How much did this bother you?
Please choose a number between 0 (not at all) and 10 (a great deal).

| Not at all | | | | | | | | | | | A great deal |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |

10a. Did urine leak when you were physically active, exerted yourself, coughed or sneezed? ☐ A-E

Never A →Skip to Item 11a

Occasionally B

Sometimes..... C

Most of the time D

All of the time E

10b. How much did this bother you?
Please choose a number between 0 (not at all) and 10 (a great deal).

| Not at all | | | | | | | | | | | A great deal |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |

11a. Did you ever leak urine for no obvious reason and without feeling that you wanted to go? ☐ A-E

Never A →Skip to Item 12a

Occasionally B

Sometimes..... C

Most of the time D

All of the time E

11b. How much did this bother you?
Please choose a number between 0 (not at all) and 10 (a great deal).

| Not at all | | | | | | | | | | | A great deal |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |

12a. Did you leak urine when you were asleep? ☐ A-E

Never A → Skip to Next Form

Occasionally B

Sometimes C

Most of the time D

All of the time E

12b. How much did this bother you?

*Please choose a number between 0
(not at all) and 10 (a great deal).*

Not at
all

A great
deal

☐
0

☐
1

☐
2

☐
3

☐
4

☐
5

☐
6

☐
7

☐
8

☐
9

☐
10