

EORTC QLQ-TC26

REGISTRY ID:																			
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FORM CODE: EOT
VERSION: A 12/08/11

Event

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SEQ #

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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.

*Now, I will ask you about symptoms you may be experiencing. Patients sometimes report the following symptoms or problems. Please indicate the extent to which you have experienced these symptoms or problems during the **past week**.*

During the past week...

- | | | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Have you had skin problems (e.g. itchy, dry)? ... | <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 had pale/cold fingers or toes? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Not at all | A little | Quite a bit | Very much |
| 3. Did you have problems with hearing? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Not at all | A little | Quite a bit | Very much |
| 4. Were you satisfied with the medical care
you received? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Not at all | A little | Quite a bit | Very much |
| 5. Were you satisfied with the information
you received about your disease or
treatment? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Not at all | A little | Quite a bit | Very much |
| 6. Did you feel uncertain about the future? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Not at all | A little | Quite a bit | Very much |
| 7. Have you been anxious about a possible
recurrence of the disease? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Not at all | A little | Quite a bit | Very much |
| 8. Have you had any problems with your job
or your education because of your
disease or treatment? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| | Not at all | A little | Quite a bit | Very much |

9. Have you been physically limited as a result of your disease or treatment?.....☐ Not at all ☐ A little ☐ Quite a bit ☐ Very much
10. Were you concerned about disruption of family life?.....☐ Not at all ☐ A little ☐ Quite a bit ☐ Very much
11. Were you concerned about your ability to have children?☐ Not at all ☐ A little ☐ Quite a bit ☐ Very much
12. Can you talk about your disease with your partner or the person who is closest to you?.....☐ Not at all ☐ A little ☐ Quite a bit ☐ Very much
13. Have you felt less masculine as a result of your disease or treatment?☐ Not at all ☐ A little ☐ Quite a bit ☐ Very much
14. Can you talk about sexuality with your partner or the person who is closest to you?.....☐ Not at all ☐ A little ☐ Quite a bit ☐ Very much
15. Do you have a testicular implant?☐ Yes ☐ No → Skip to next form
16. Are you satisfied with your testicular implant?.....☐ Not at all ☐ A little ☐ Quite a bit ☐ Very much