Quality of Life - Gastric Cancer

REGISTRY ID:													FORM CODE: FAGA VERSION:A 07/15/11	Event			SEQ #		

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….

	Not at all	A little bit	Somewhat	Quite a bit	Very much
1. You were losing weight.	☐	☐	☐	☐	☐
2. You had a loss of appetite.	☐	☐	☐	☐	☐
3. You were bothered by reflux or heartburn	☐	☐	☐	☐	☐
4. You were able to eat the foods that you like……	☐	☐	☐	☐	☐
5. You had discomfort or pain when you ate..	☐	☐	☐	☐	☐
6. You had a feeling of fullness or heaviness in your stomach area……..	☐	☐	☐	☐	☐
7. You had swelling or cramps in your stomach area.	☐	☐	☐	☐	☐
8. You had trouble swallowing food.	☐	☐	☐	☐	☐
9. You were bothered by a change in your eating habits.	☐	☐	☐	☐	☐

	Not at all	A little bit	Somewhat	Quite a bit	Very much
10. You were able to enjoy meals with family or friends	☐	☐	☐	☐	☐
11. Your digestive problems interfered with your usual activities	☐	☐	☐	☐	☐
12. You avoided going out to eat because of your illness	☐	☐	☐	☐	☐
13. You worried about having stomach problems	☐	☐	☐	☐	☐
14. You had discomfort or pain in your stomach area	☐	☐	☐	☐	☐
15. You were bothered by gas (flatulence)	☐	☐	☐	☐	☐
16. You had diarrhea (diarrhoea)	☐	☐	☐	☐	☐
17. You felt tired	☐	☐	☐	☐	☐
18. You felt weak all over	☐	☐	☐	☐	☐
19. Because of your illness, you had difficulty planning for the future	☐	☐	☐	☐	☐

Gastric Cancer Symptoms

REGISTRY ID:													FORM CODE: EOGA VERSION:A 04/12/11	Event			SEQ #		

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**.*

	Not at all	A little	Quite a bit	Very much
1. Have you had problems eating solid foods?.....	☐	☐	☐	☐
2. Have you had problems eating liquidized or soft foods?.....	☐	☐	☐	☐
3. Have you had problems drinking liquids?.....	☐	☐	☐	☐
4. Have you had discomfort when eating?.....	☐	☐	☐	☐
5. Did you have a bloated feeling in your abdomen?.....	☐	☐	☐	☐
6 Have you had trouble with acid or bile coming into your mouth?.....	☐	☐	☐	☐
7. Have you had trouble with belching?.....	☐	☐	☐	☐
8. Has it taken you a long time to complete your meals?.....	☐	☐	☐	☐
9. Did food and drink taste different from usual?.....	☐	☐	☐	☐