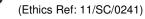
Biliary Tract Cancer QoL Validation Study





Site ID:

Patient Study ID:

Today's date (Day, Month, Year): ___/ ___/ ____/

Patients sometimes report that they have the following symptoms or problems. Please indicate the extent to which you have experienced these symptoms or problems <u>during the past week</u>. Please answer by circling the number that best applies to you.

During the past week:		Not at all	A little	Quite a bit	Very much
31.	Have you had trouble with eating?	1	2	3	4
32.	Have you felt full up too quickly after beginning to eat?	1	2	3	4
33.	Have you had problems with your sense of taste?	1	2	3	4
34.	Were you restricted in the types of food you can eat as a result of your disease or treatment?	1	2	3	4
35.	Have your skin or eyes been yellow (jaundiced)?	1	2	3	4
36.	Have you had itching?	1	2	3	4
37.	Have you been worried about your skin being yellow?	1	2	3	4
38.	Have you been less active than you would like to be?	1	2	3	4
39.	Have you felt "slowed down"?	1	2	3	4
40.	Have you felt lacking in energy?	1	2	3	4
41.	Did you have pain during the night?	1	2	3	4
42.	Have you had pain in your stomach area?	1	2	3	4
43.	Have you had pain in your back?	1	2	3	4
44.	Did you have a bloated feeling in your abdomen?	1	2	3	4
45.	Have you felt stressed?	1	2	3	4
46.	Have you felt less able to enjoy yourself?	1	2	3	4
47.	Have you worried about your health in the future?	1	2	3	4
48.	Were you worried about your family in the future?	1	2	3	4
49.	To what extent have you been troubled with side-effects from your treatment?	1	2	3	4
50.	Have you had difficulties with drainage tubes/ bags?	1	2	3	4
51.	Have you worried about losing weight?	1	2	3	4
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