EORTC QLQ – BIL21

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 during the past week. 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