General Questionnaire

Study ID#: \_\_\_\_\_

**Part I.** How **severe** are your symptoms?

People with cancer frequently have symptoms that are caused by their disease or by their treatment. We ask you to rate how severe the following symptoms have been ***in the last 24 hours*.** Please fill in the circle below from 0 (symptom has not been present) to 10 (the symptom was as bad as you can imagine it could be) for each item.

Not present

As bad as you can imagine

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 1. Your **pain** at its WORST? |  |  |  |  |  |  |  |  |  |  |  |
| 2. Your **fatigue (tiredness)** at its WORST? |  |  |  |  |  |  |  |  |  |  |  |
| 3. Your **nausea** at its WORST? |  |  |  |  |  |  |  |  |  |  |  |
| 4. Your **disturbed sleep** at its WORST? |  |  |  |  |  |  |  |  |  |  |  |
| 5. Your feeling of being **distressed (upset)** at its WORST? |  |  |  |  |  |  |  |  |  |  |  |
| 6. Your **shortness of breath** at its WORST? |  |  |  |  |  |  |  |  |  |  |  |
| 7. Your problem with **remembering things** at its WORST? |  |  |  |  |  |  |  |  |  |  |  |
| 8. Your problem with **lack of appetite** at its WORST? |  |  |  |  |  |  |  |  |  |  |  |
| 9. Your feeling **drowsy (sleepy)** at its WORST? |  |  |  |  |  |  |  |  |  |  |  |
| 10. Your having a **dry mouth** at its WORST? |  |  |  |  |  |  |  |  |  |  |  |
| 11. Your feeling **sad** at its WORST? |  |  |  |  |  |  |  |  |  |  |  |
| 12. Your **vomiting** at its WORST? |  |  |  |  |  |  |  |  |  |  |  |
| 13. Your **numbness or tingling** at its WORST? |  |  |  |  |  |  |  |  |  |  |  |
| 14. Your problem with **mucus** in our mouth and throat at its WORST? |  |  |  |  |  |  |  |  |  |  |  |
| 15. Your difficulty **swallowing/chewing** at its WORST? |  |  |  |  |  |  |  |  |  |  |  |

Not present

As bad as you can imagine

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 16. Your **choking/coughing** (food/liquids going down the wrong pipe) at its WORST? |  |  |  |  |  |  |  |  |  |  |  |
| 17. Your difficulty with **voice/speech** at its WORST? |  |  |  |  |  |  |  |  |  |  |  |
| 18. Your **skin pain/burning/rash** at its WORST? |  |  |  |  |  |  |  |  |  |  |  |
| 19. Your **constipation** at its WORST? |  |  |  |  |  |  |  |  |  |  |  |
| 20. Your problem with **tasting food** at its WORST? |  |  |  |  |  |  |  |  |  |  |  |
| 21. Your **mouth/throat sores** at their WORST? |  |  |  |  |  |  |  |  |  |  |  |
| 22. Your problem with your **teeth or gums** at its WORST? |  |  |  |  |  |  |  |  |  |  |  |

**Part II. How have your symptoms interfered with your life?**

**Symptoms frequently interfere with how we feel and function. How much have your symptoms interfered with the following items in the last 24 hours?**

|  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | 0 | 1  As bad as you can imagine | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 23. **General activity?** |  |  |  |  |  |  |  |  |  |  |  |
| 24. **Mood?** |  |  |  |  |  |  |  |  |  |  |  |
| 25. **Work (including work around the house)?** |  |  |  |  |  |  |  |  |  |  |  |
| 26. **Relations with other people?** |  |  |  |  |  |  |  |  |  |  |  |
| 27. **Walking?** |  |  |  |  |  |  |  |  |  |  |  |
| 28. **Enjoyment of life?** |  |  |  |  |  |  |  |  |  |  |  |

Not present

M.D. Anderson Symptom Inventory – Head & Neck (MDASI-HN)

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