

POS-S RENAL – PATIENT COMPLETION

Below is a list of symptoms, which you may or may not have experienced. Please put a tick in the box to show how you feel each of these symptoms has affected you and how you have been feeling over the **past week**.

	Not at all No effect	Slightly but not bothered to be rid of it	Moderately limits some activity or concentration	Severely activities or concentration markedly affected	Overwhelmingly unable to think of anything else
Pain	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
Shortness of breath	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
Weakness or lack of energy	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
Nausea (feeling like you are going to be sick)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
Vomiting (being sick)	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
Poor appetite	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
Constipation	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
Mouth problems	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
Drowsiness	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
Poor mobility	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
Itching	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
Difficulty sleeping	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
Restless legs or difficulty keeping legs still	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
Feeling anxious	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
Feeling depressed	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
Changes in skin	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
Diarrhoea	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
Any other symptoms:					
	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4
	<input type="checkbox"/> _0	<input type="checkbox"/> _1	<input type="checkbox"/> _2	<input type="checkbox"/> _3	<input type="checkbox"/> _4

Which symptom has affected you the most? _____

Which symptom has improved the most? _____



**Palliative care Outcome Scale – Symptoms
RENAL**

NAME:

PATIENT NUMBER:

www.pos-pal.org

www.csi.kcl.ac.uk