EORTC QLQ-C15-PAL (version 1)

We are interested in some things about you and your health. Please answer all of the questions yourself by circling the number that best applies to you. There are no "right" or "wrong" answers. The information that you provide will remain strictly confidential.

Please fill in your initials: |__|__|__|__|
Your birthdate (Day, Month, Year): |__|__||__|__||__|__|__|__|
Today's date (Day, Month, Year): |__|__||__|__||__|__|__|__|

	Not at All	A Little	Quite a Bit	Very Much
1. Do you have any trouble taking a short walk outside of the house?	1	2	3	4
2. Do you need to stay in bed or a chair during the day?	1	2	3	4
3. Do you need help with eating, dressing, washing yourself or using the toilet?	1	2	3	4

During the past week:

	Not at All	A Little	Quite a Bit	Very Much
4. Were you short of breath?	1	2	3	4
5. Have you had pain?	1	2	3	4
6. Have you had trouble sleeping?	1	2	3	4
7. Have you felt weak?	1	2	3	4
8. Have you lacked appetite?	1	2	3	4
9. Have you felt nauseated?	1	2	3	4

Please go on to the next page

During the past week:	**Not at All**	**A Little**	**Quite a Bit**	**Very Much**
10. Have you been constipated?	1	2	3	4
11. Were you tired?	1	2	3	4
12. Did pain interfere with your daily activities?	1	2	3	4
13. Did you feel tense?	1	2	3	4
14. Did you feel depressed?	1	2	3	4

For the following question please circle the number between 1 and 7 that best applies to you

15. How would you rate your overall quality of life during the past week?

1	2	3	4	5	6	7
Very poor						Excellent

16. Have you had any additional, important symptoms or problems that have not been mentioned in the questions above?

☐ No.

☐ Yes. Please write the most important (up to three), and rate to what extent you have had the symptoms or problems during the past week:

During the past week, to what to extent have you had:	**Not at All**	**A Little**	**Quite a Bit**	**Very Much**
Symptom/problem A: _____	1	2	3	4
Symptom/problem B: _____	1	2	3	4
Symptom/problem C: _____	1	2	3	4