Municipality number: | | | Registration number: | | | Patient number: P | | | |

12 w

Cancer care in Romsdal region

Questionnaire for patients

Completion date: | | . | | . 2 0 | |

3328

Municipality: ☐☐ Registration: ☐☐ Patient: ☐☐☐

Living situation
(Mark with a cross for the option that suits you)

- ☐ Alone
- ☐ Together with spouse/partner
- ☐ Together with spouse/partner and children (also grownup)
- ☐ Together with children (also grownup)
- ☐ Together with other adults (family or others)

Housing conditions
(Mark with a cross for the option that suits you)

- ☐ Detached house
- ☐ Terraced house
- ☐ Block/apartment/flat
- ☐ Generational housing
- ☐ Care/Social apartment
- ☐ Retirement home
- ☐ Nursing home

☐ Housing with rental

Professional life
(several marks possible)

- ☐ Professionally active ☐☐☐ % position
- ☐ Self-employed
- ☐ Student
- ☐ Job seeker/unemployed/laid off
- ☐ Sick leave ☐☐☐ % sykmeldt
- ☐ Workcleranceallowance (AAP)
- ☐ Work disabled ☐☐☐ % work disable
- ☐ Retirement pension ☐☐☐ % pension

Other benefits / social security schemes

Did family apply for 60-days care money? ☐ Yes ☐ No

Did family granted 60-days care money? ☐ Ye ☐ No

If yes, which date: ☐☐.☐☐.☐☐☐☐

Municipality: ☐☐ Registration: ☐☐ Patient: ☐☐☐

Please mark the number that best describes how you feel NOW:

No Pain	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	Worst Possible Pain
No Tiredness (Tiredness = lack of energy)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	Worst Possible Tiredness
No Drowsiness (Drowsiness = feeling sleepy)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	Worst Possible Drowsiness
No Nausea	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	Worst Possible Nausea
No Lack of Appetite	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	Worst Possible Lack of Appetite
No Shortness of Breath	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	Worst Possible Shortness of Breath
No Depression (depresjon = å føle seg nedstemt)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	Worst Possible Depression
No anxiety (Anxiety = feeling nervous)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	Worst Possible Anxiety
Best Wellbeing (Wellbeing = how you feel overall)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	Worst Possible Wellbeing
Best imaginable sleep	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	Worst imaginable sleep
No Constipation (constipation = obstipation)	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	Worst Possible Constipation
No Vomiting	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	Worst Possible Vomiting

Municipality: ☐☐ Registration: ☐☐ Patient: ☐☐☐

Please put a cross under the number that best describes the most severe pain you have had during **the last 24 hours**.

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

No pain — Worst Possible Pain

Please put a cross under the number that best indicates how severe your pain has been **on average.**

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

No Pain — Worst Possible Pain

To what extent has treatment or medication relieved your pain in **the past 24 hours**? Please put a cross under the percentage that shows how much pain relief you have had.

0%	10%	20%	30%	40%	50%	60%	70%	80%	90%	100%
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

No Relief — Complete Relief

Breakthrough pain can be defined as a short-term worsening of pain. It may be a worsening of the usual, constant pain you always have (your constant pain) OR it could be a pain that is different from your constant pain.

Have you had breakthrough pain **in the last 24 hours?** ☐ Yes ☐ No

Approximately how many times **in the past 24 hours** have you had this **breakthrough pain**? Please include all episodes, regardless of whether you took medication for them or not.

Number of episodes: ☐☐

When this breakthrough pain is at its worst, how would you describe the pain on a scale of 0-10, where 0 is "no pain" and 10 is "worst possible pain"? Please mark the number that best represents the intensity of your breakthrough pain.

☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

No Pain — Worst Possible Pain

Municipality: ☐☐ Registration: ☐☐ Patient: ☐☐☐

During the **last 2 weeks**, how often have you been bothered by one or more of the following problems?

	Not at all	Some days	More than 7 days	Nearly every day
Little interest or joy in doing things	☐	☐	☐	☐
Feeling down, depressed or filled with hopelessness	☐	☐	☐	☐
Difficulty falling asleep or sleeping through the night without waking - or sleeping too much	☐	☐	☐	☐
Feeling tired or lethargic	☐	☐	☐	☐
Poor appetite or eating too much	☐	☐	☐	☐
Been unhappy with yourself or felt like a failure - or felt like you've let yourself or your family down	☐	☐	☐	☐
Difficulty concentrating on things, such as reading the newspaper or watching TV	☐	☐	☐	☐
Did you move or speak so slowly that others might have noticed? Or the opposite - felt so restless that you have been moving much more than usual	☐	☐	☐	☐
Thoughts that you might as well be dead or would otherwise harm yourself	☐	☐	☐	☐

If you have experienced one or more of the problems mentioned, to what extent have the problems made it difficult for you to carry out your work, arrange things at home or get along with others?

- ☐ Not difficult at all
- ☐ A little bit difficult
- ☐ Very difficult
- ☐ Extremely difficult

Weight

I weigh approx ☐☐☐.☐ kg

For the past two weeks, my weight has: (choose one)

☐ Decreased ☐ Been unchanged ☐ Increased

Food intake

Compared to my normal, my food intake has **over the last 4 weeks** been: (choose one)

☐ Unchanged

☐ More than usual

☐ Less than usual

I eat and drink now: (only answered if you eat less than usual) (choose one answer option)

☐ Usual food, but less than usual

☐ Only liquid

☐ Only nutritional drinks

☐ Very little of everything

☐ Tube feeding or intravenous feeding only

Municipality: ☐☐ Registration: ☐☐ Patient: ☐☐☐

	Not at all	Little	Some	Very much
Do you have difficulties going for a short walk outdoors?	☐	☐	☐	☐
Do you have to lie in bed or sit in a chair during the day?	☐	☐	☐	☐
Do you need help eating, dressing, washing or going to the toilet?	☐	☐	☐	☐

During <u>the last week:</u>

Have you been short of breath?	☐	☐	☐	☐
Have you had pain?	☐	☐	☐	☐
Have you had sleep problems?	☐	☐	☐	☐
Have you felt lethargic?	☐	☐	☐	☐
Have you had a bad appetite?	☐	☐	☐	☐
Have you been nauseous?	☐	☐	☐	☐
Have you had constipation?	☐	☐	☐	☐
Have you felt tired?	☐	☐	☐	☐
Has pain affected your daily activities?	☐	☐	☐	☐
Have you been feeling tense?	☐	☐	☐	☐
Have you felt depressed?	☐	☐	☐	☐

In response to the following questions, put a cross next to the number from 1 to 7 that best describes your condition

How has your quality of life been during **the past week?**

☐	☐	☐	☐	☐	☐	☐
1	**2**	**3**	**4**	**5**	**6**	**7**

Very poor Excellent

Municipality: ☐☐ Registration: ☐☐ Patient: ☐☐☐

During <u>the last week</u>:

	Not at all	Litl	Some	Very much
Have you been worried about how your spouse and family will cope in the future?	☐	☐	☐	☐
Have you had support from family and friends?	☐	☐	☐	☐
Have your family / friends been of use to you?	☐	☐	☐	☐
Have you been able to share your feelings with others?	☐	☐	☐	☐
Have you had good contact with others outside the family, such as friends, workmates or others?	☐	☐	☐	☐

We know from experience that you might change your mind over time. We would like to get your opinion about the next questions again, independently of what you have answered earlier.

Many people, both healthy and ill, think about where they in time would like to die. When that time comes, and you yourself could choose, where would you prefer to die?

☐ Home ☐ Hospital

☐ Nursing home ☐ Other, specify: _____

If you could choose where you would spend the last part of your life, where would you most like to receive treatment, care and attention?

☐ Home ☐ Home

☐ Nursing home ☐ Other, specify: _____

Think three months into the future. How important is it to you, in the next three months, that you receive treatment and care in your home without admission to hospital or a nursing home?

☐ Not important at all ☐ Little important ☐ Quite important ☐ Very important

We are interested in the information you have received about your illness and how it is treated.	Not at all	Littl	Some	Very much
Are you satisfied with information you have received?	☐	☐	☐	☐
By and large, the information you got has been helpful?	☐	☐	☐	☐

Municipality: Registration: Patient:

Show which statements best fit your state of health **today** by putting a cross in one of the boxes outside each of the groups below.

Walking

- ☐ I have no problems walking around
- ☐ I have little problems walking around
- ☐ I am bedridden

Personal care

- ☐ I have no problems with personal care
- ☐ I have some trouble washing or dressing myself
- ☐ I am unable to wash or dress myself

Common tasks (e.g. work, studies, housework, family or leisure activities)

- ☐ I have no problems carrying out my usual tasks
- ☐ I'm having some trouble doing my usual tasks
- ☐ I am unable to carry out my usual tasks

Pain/discomfort

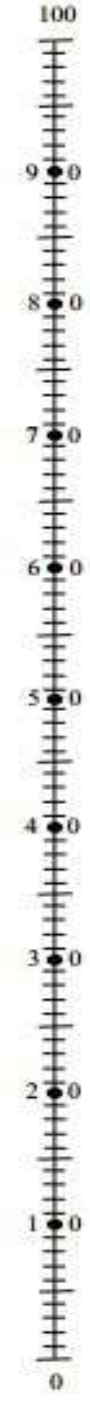
- ☐ I have neither pain nor discomfort
- ☐ I have moderate pain or discomfort
- ☐ I have severe pain or discomfort

Anxiety/depression

- ☐ I am neither anxious nor depressed
- ☐ I am somewhat anxious or depressed
- ☐ I am very anxious or depressed

Municipality: Registration: Patient:

Best imaginable state of health



Worst imaginable state of health

To help people say how good or bad a state of health is, we have created a scale (much like a thermometer) where the best state you can imagine is marked 100 and the worst state you can imagine is marked 0.

We would like you to indicate on this scale how good or bad your state of health is today, in your opinion. Please do this by drawing a line from the box below to the point on the scale that shows how good or bad your health is **today**

Din egen helsetilstand i dag

Do not write here

Municipality: ☐☐ Registration: ☐☐ Patient: ☐☐☐

Mark each line to indicate your answer as it applies to **the last week**

	Not at all	Litll	Certain extend	Much	Very much
I feel an inner peace	☐	☐	☐	☐	☐
I have reason to live	☐	☐	☐	☐	☐
I've had a lot done in my life	☐	☐	☐	☐	☐
Hard time to find peace of mind	☐	☐	☐	☐	☐
I feel that my life has a purpose	☐	☐	☐	☐	☐
I am able to go inside myself to find comfort	☐	☐	☐	☐	☐
I feel a kind of harmony inside me	☐	☐	☐	☐	☐
My life lacks meaning and purpose	☐	☐	☐	☐	☐

	Doesn't match at all					Totally agree
	0	**1**	**2**	**3**	**4**	**5**
Religion is important part of my life	☐	☐	☐	☐	☐	☐
It is important for me to pray	☐	☐	☐	☐	☐	☐
I draw strength from my faith	☐	☐	☐	☐	☐	☐

Have all questions been answered? ☐ Yes ☐ No

Filled out: (Putt one mark)

- ☐ Patient
- ☐ Patient with some help from relatives and/or health care personnel
- ☐ Relatives interviewed the patient and filled in the form
- ☐ Healthcare personnel interviewed the patient and filled in the form

Thank you for taking you time to answer the questions