Identification of Rare Variants in Candidate Genes Associated with Chemotherapy-Induced Peripheral Neuropathy

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Journal: Molecular Neurobiology

Supplement 1: Baseline Questionnaire

QUT ihbi Institute of Health and Biomedical Innovation

HOLY SPIRIT NORTHSIDE PRIVATE HOSPITAL
A PARTNERSHIP OF ST VINCENT'S HEALTH AUSTRALIA AND THE HOLY SPIRIT MISSIONARY SISTERS

TARGET: Individually Tailored Health Care Program for Cancer Patients : BASELINE SURVEY

Thank you for your participation in the TARGET Individually Tailored Health Care program for Cancer Patients project that we are conducting with Holy Spirit Northside Private Hospital.

The following questionnaire asks about you and your health and will take you approximately 20 minutes to complete. Please complete the questionnaire and return your completed consent form and survey to the nursing staff in the Day Oncology Unit.

This information will assist us in the development of the best possible services and interventions to address the needs of people undergoing chemotherapy or other anti-cancer therapies.

If you have any health concerns please contact the nursing staff in the Day Oncology Unit at Holy Spirit Northside Private Hospital.

If you have any questions regarding completion of this questionnaire or your participation in this study you can contact Dr Kimberly Alexander on Ph: 07 3138 6445/0417 647 651 or email k.alexander@qut.edu.au

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Today's date ____ / _____/ _____

Patient ID _____

First Name _____

Middle Name _____

Last Name _____

Date of Birth: ____ / _____/ _____

Gender

☐$_0$ Male

☐$_1$ Female

Diagnosis: _____

Date of Diagnosis: ____ / _____/ _____

Email: _____

Phone number: _____

Address: _____

_____

Postcode: _____

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Marital status

What is your relationship status?

- ☐ 0 Never married / partnered
- ☐ 1 Married / partnered
- ☐ 2 Divorced / separated
- ☐ 3 Widowed

Educational level

Please indicate highest level of schooling completed

- ☐ 0 None
- ☐ 1 Primary
- ☐ 2 Secondary
- ☐ 3 Certificate / Diploma
- ☐ 4 Bachelor or Postgraduate

Living Status

Which statement best describes your living arrangements

- ☐ 0 I live with my partner/spouse/family/friends
- ☐ 1 I live alone
- ☐ 2 I live in a nursing home, hospital or other long-term care home
- ☐ 8 Other

Responsibilities

Do you have responsibilities for children at home?

- ☐ 0 No
- ☐ 1 Yes

Do you have responsibilities for elders at home?

- ☐ 0 No
- ☐ 1 Yes

Employment

Are you

☐$_0$ Employed _____ Hours/week

☐$_1$ Self-Employed _____ Hours/week

☐$_2$ Unemployed

☐$_3$ Retired

What is your annual household income

☐$_0$ < $30,000

☐$_1$ $30,000 to $70,000

☐$_2$ $70,000 to $100,000

☐$_3$ > $100,000

Ethnicity

What is your ethnicity? (please tick 1 option)

☐$_0$ British/Scottish/Welsh/Irish

☐$_1$ Southern Europe

☐$_2$ Central/Eastern Europe

☐$_3$ Northern/Western Europe

☐$_4$ Indigenous Australian

☐$_5$ South East Asian

☐$_6$ North East Asian

☐$_7$ South Asian

☐$_8$ Middle Eastern

☐$_9$ Pacific Islander

☐$_{10}$ Other

Co-morbidities

The following is a list of problems. Please indicate if you currently have the problem in the first column. If you do not have the problem, skip to the next problem. If you do have the problem, please indicate in the second column if you receive medications or some other type of treatment for the problem. In the third column indicate if the problem limits any of your activities. Finally, indicate all medical conditions that are not listed under 'other medical problems' at the end of the page.

Problem	Do you have the problem?		Do you receive treatment for it?		Does it limit your activities?	
	No 0	Yes 1	No 0	Yes 1	No 0	Yes 1
Heart disease	N	Y	N	Y	N	Y
High blood pressure	N	Y	N	Y	N	Y
Lung disease	N	Y	N	Y	N	Y
Diabetes	N	Y	N	Y	N	Y
Ulcer or stomach disease	N	Y	N	Y	N	Y
Kidney disease	N	Y	N	Y	N	Y
Liver disease	N	Y	N	Y	N	Y
Anaemia or other blood disease	N	Y	N	Y	N	Y
Cancer	N	Y	N	Y	N	Y
Depression	N	Y	N	Y	N	Y
Osteoarthritis, degenerative arthritis	N	Y	N	Y	N	Y
Back pain	N	Y	N	Y	N	Y
Rheumatoid arthritis	N	Y	N	Y	N	Y
Other medical problem (please write in)	N	Y	N	Y	N	Y
_____	N	Y	N	Y	N	Y
_____	N	Y	N	Y	N	Y
_____	N	Y	N	Y	N	Y

General Health

Date ____ / _____/ _____ Current Weight _____ Current Height: _____

Have you lost weight without trying?

☐$_0$ No

☐$_1$ Yes

☐$_9$ Unsure

If yes, how much weight (kg) have you lost

☐$_0$ 1 - 5 kilograms

☐$_1$ 6 - 10 kilograms

☐$_2$ 11 - 15 kilograms

☐$_3$ More than 15 kilograms

☐$_9$ Unsure

Have you been eating poorly due to decreased appetite?

☐$_0$ No

☐$_1$ Yes

Exercise

What is your current level of exercise?

☐$_0$ No exercise

☐$_1$ Limited exercise

☐$_2$ Regular exercise

Type of activity_____

Duration _____

Intensity _____

Low (e.g. walking)

Moderate (e.g. cycling)

Vigorous (e.g. running)

Frequency_____ times/week

Smoking status

Are you

☐$_0$ Current smoker

☐$_1$ Former smoker

Age started_____

Age stopped_____

Cigarettes per week_____

☐$_2$ Never smoked

Alcohol

Current alcohol consumption

Number of standard drinks/week _____

During the last 12 months, how many standard alcoholic drinks did you have on a typical day when you drank alcohol?

Number of standard drinks/week _____

Pain medication use

Do you take any of the following:

Over-the-counter pain medicine

☐$_0$ No

☐$_1$ Yes

Strong pain medicine, also known as opioids

☐$_0$ No

☐$_1$ Yes

Other medication use

Do you regularly take medicines including over-the-counter supplements, natural or prophylactic medicines?

☐$_0$ No

☐$_1$ Yes

If yes, what are you taking?

Prescription or non prescription medication	Reason(s) why you are taking it

Are you now receiving any of the following?

☐	Acupuncture	☐	Aromatherapy	☐	Art, Music or Dance Therapy
☐	Chiropractic therapy	☐	Counselling	☐	Supervised exercise program
☐	Massage	☐	Naturopathic medicine	☐	Qigong or Tai Chi
☐	Reiki	☐	Therapeutic / Healing touch	☐	Yoga
☐	Other complementary or alternative therapies, please specify				

Reasons why you are using any of the above complementary or alternative therapies:

_____

_____

_____

Patient family history of cancer

Do you have a first degree relative (father, brother, son, mother, sister, daughter) with a cancer diagnosis?

☐ 0 No

☐ 1 Yes

☐ 9 Unknown

If yes, please list the type of cancer _____

Current Activity

Which of the following statements best describes you at this time?

☐ 0 I am fully active and able to carry out activities the same as before my cancer diagnosis, without any restrictions

☐ 1 I have difficulty with physically strenuous activity but I am able to walk and carry out work that is light or based in one location; such as light housework or office work

☐ 2 I can walk and take care of myself, but I am not able to carry out work activities; I am up and about more than half the hours that I am awake

☐ 3 I am capable only of limited self-care and spend more than half the hours that I am awake in bed or in a chair

☐ 4 I am completely disabled, cannot carry on any self-care and am totally confined to a bed or chair

Please tick the box next to the response that best fits your situation in the previous 30 days

Do you need any help looking after yourself? (*For example: dressing, bathing, eating*)

- ☐ 1 I need no help at all
- ☐ 2 Occasionally I need some help with personal care tasks
- ☐ 3 I need help with the more difficult personal care tasks
- ☐ 4 I need daily help with most or all personal care tasks

When doing household tasks (*For example: cooking, cleaning the house, washing*)

- ☐ 1 I need no help at all
- ☐ 2 Occasionally I need some help with household tasks
- ☐ 3 I need help with the more difficult household tasks
- ☐ 4 I need daily help with most or all household tasks

Thinking about how easily you can get around your home and community

- ☐ 1 I get around my home and community by myself without any difficulty
- ☐ 2 I find it difficult to get around my home and community by myself
- ☐ 3 I cannot get around the community by myself, but I can get around my home with some difficulty
- ☐ 4 I cannot get around either the community or my home by myself

Because of your health, your relationships generally (*for example: with your friends, partner or parents*)

- ☐ 1 Are very close and warm
- ☐ 2 Are sometimes close and warm
- ☐ 3 Are seldom close and warm
- ☐ 4 I have no close and warm relationships

Thinking about your relationship with other people

☐$_1$ I have plenty of friends, and am never lonely

☐$_2$ Although I have friends, I am occasionally lonely

☐$_3$ I have some friends, but am often lonely for company

☐$_4$ I am socially isolated and feel lonely

Thinking about your health and your relationship with your family

☐$_1$ My role in the family is unaffected by my health

☐$_2$ There are some parts of my family role I cannot carry out

☐$_3$ There are many parts of my family role I cannot carry out

☐$_4$ I cannot carry out any part of my family role

Thinking about your vision, including when using your glasses or contact lenses if needed

☐$_1$ I see normally

☐$_2$ I have some difficulty focusing on things, or I do not see them sharply
For example: small print, a newspaper or seeing objects in the distance

☐$_3$ I have a lot of difficulty seeing things. My vision is blurred.
For example: I can see just enough to get by with

☐$_4$ I only see general shapes, or am blind
For example: I need a guide to move around

Thinking about your hearing, including using your hearing aid if needed

☐$_1$ I hear normally

☐$_2$ I have some difficulty hearing or I do not hear clearly
For example: I ask people to speak up, or turn up the TV or radio volume

☐$_3$ I have difficulty hearing things clearly
For example: Often I do not understand what is said. I usually do not take part in conversations because I cannot hear what is said

☐$_4$ I hear very little indeed
For example: I cannot fully understand loud voices speaking directly to me

When you communicate with others (*For example: by talking, listening, writing or signing*)

- ☐ 1 I have no trouble speaking to them or understanding what they are saying
- ☐ 2 I have some difficulty being understood by people who do not know me. I have no trouble understanding what others are saying to me
- ☐ 3 I am only understood by people who know me well. I have great trouble understanding what others are saying to me
- ☐ 4 I cannot adequately communicate with others

Thinking about how you sleep

- ☐ 1 I am able to sleep without difficulty most of the time
- ☐ 2 My sleep is interrupted some of the time, but I am usually able to go back to sleep without difficulty
- ☐ 3 My sleep is interrupted most nights, but I am usually able to go back to sleep without difficulty
- ☐ 4 I sleep in short bursts only. I am awake most of the night.

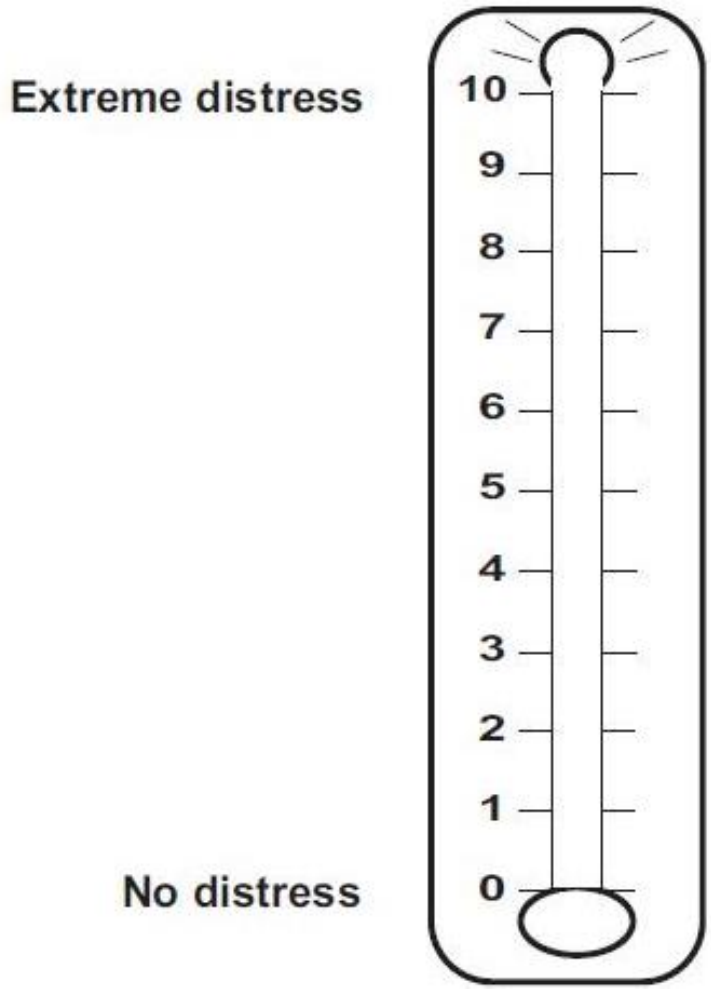
Thinking about how you generally feel

- ☐ 1 I do not feel anxious, worried or depressed
- ☐ 2 I am slightly anxious, worried or depressed
- ☐ 3 I feel moderately anxious, worried or depressed
- ☐ 4 I am extremely anxious, worried or depressed

How much pain or discomfort do you experience

- ☐ 1 None at all
- ☐ 2 I have moderate pain
- ☐ 3 I suffer from severe pain
- ☐ 4 I suffer unbearable pain

Please circle the number (0-10) that best describes how much distress you have been experiencing in the past 30 days including today.



Symptoms

As individuals go through treatment for their cancer they sometimes experience different symptoms and side effects. For each question, please mark the response that best describes your experiences over the past 30 days.

Gastrointestinal

In the last 30 days, what was the SEVERITY of your PROBLEMS WITH TASTING FOOD OR DRINK at their WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, what was the SEVERITY of your DECREASED APPETITE at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, how much did DECREASED APPETITE INTERFERE with your usual or daily activities?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

In the last 30 days, how OFTEN did you have NAUSEA?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Almost constantly

In the last 30 days, what was the SEVERITY of your NAUSEA at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, how OFTEN did you have VOMITING?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Almost constantly

In the last 30 days, what was the SEVERITY of your VOMITING at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, how OFTEN did you have HEARTBURN?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Almost constantly

In the last 30 days, what was the SEVERITY of your HEARTBURN at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, did you have any INCREASED PASSING OF GAS (FLATULENCE)?

☐ No ☐ Yes

In the last 30 days, how OFTEN did you have BLOATING OF THE ABDOMEN (BELLY)?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Almost constantly

In the last 30 days, what was the SEVERITY of your BLOATING OF THE ABDOMEN (BELLY) at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, how OFTEN did you have HICCUPS?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Almost constantly

In the last 30 days, what was the SEVERITY of your HICCUPS at their WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, what was the SEVERITY of your CONSTIPATION at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, how OFTEN did you have LOOSE OR WATERY STOOLS (DIARRHOEA)?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Almost constantly

In the last 30 days, how OFTEN did you have PAIN IN THE ABDOMEN (BELLY AREA)?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Almost constantly

In the last 30 days, what was the SEVERITY of your PAIN IN THE ABDOMEN (BELLY AREA) at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, how much did PAIN IN THE ABDOMEN (BELLY AREA) INTERFERE with your usual or daily activities?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

In the last 30 days, how OFTEN did you LOSE CONTROL OF BOWEL MOVEMENTS?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Almost constantly

In the last 30 days, how much did LOSS OF CONTROL OF BOWEL MOVEMENTS INTERFERE with your usual or daily activities?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

Pain

In the last 30 days, how OFTEN did you have PAIN?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Almost constantly

In the last 30 days, what was the SEVERITY of your PAIN at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, how much did PAIN INTERFERE with your usual or daily activities?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

In the last 30 days, how OFTEN did you have a HEADACHE?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Almost constantly

In the last 30 days, what was the SEVERITY of your HEADACHE at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, how much did your HEADACHE INTERFERE with your usual or daily activities?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

In the last 30 days, how OFTEN did you have ACHING MUSCLES?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Almost constantly

In the last 30 days, what was the SEVERITY of your ACHING MUSCLES at their WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, how much did ACHING MUSCLES INTERFERE with your usual or daily activities?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

In the last 30 days, how OFTEN did you have ACHING JOINTS (SUCH AS ELBOWS, KNEES, SHOULDERS)?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Almost constantly

In the last 30 days, what was the SEVERITY of your ACHING JOINTS (SUCH AS ELBOWS, KNEES, SHOULDERS) at their WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, how much did ACHING JOINTS (SUCH AS ELBOWS, KNEES, SHOULDERS) INTERFERE with your usual or daily activities?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

Neurological

In the last 30 days, what was the SEVERITY of your NUMBNESS OR TINGLING IN YOUR HANDS OR FEET at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, how much did NUMBNESS OR TINGLING IN YOUR HANDS OR FEET INTERFERE with your usual or daily activities?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

In the last 30 days, what was the SEVERITY of your DIZZINESS at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, how much did DIZZINESS INTERFERE with your usual or daily activities?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

Attention / memory

In the last 30 days, what was the SEVERITY of your PROBLEMS WITH CONCENTRATION at their WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, how much did PROBLEMS WITH CONCENTRATION INTERFERE with your usual or daily activities?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

In the last 30 days, what was the SEVERITY of your PROBLEMS WITH MEMORY at their WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, how much did PROBLEMS WITH MEMORY INTERFERE with your usual or daily activities?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

Sleep / Wake

In the last 30 days, what was the SEVERITY of your INSOMNIA (INCLUDING DIFFICULTY FALLING ASLEEP, STAYING ASLEEP, OR WAKING UP EARLY) at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, how much did INSOMNIA (INCLUDING DIFFICULTY FALLING ASLEEP, STAYING ASLEEP, OR WAKING UP EARLY) INTERFERE with your usual or daily activities?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

In the last 30 days, what was the SEVERITY of your FATIGUE, TIREDNESS, OR LACK OF ENERGY at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, how much did FATIGUE, TIREDNESS, OR LACK OF ENERGY INTERFERE with your usual or daily activities?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

Mood

In the last 30 days, how OFTEN did you feel ANXIETY?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Almost constantly

In the last 30 days, what was the SEVERITY of your ANXIETY at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, how much did ANXIETY INTERFERE with your usual or daily activities?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

In the last 30 days, how OFTEN did you FEEL THAT NOTHING COULD CHEER YOU UP?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Almost constantly

In the last 30 days, what was the SEVERITY of your FEELINGS THAT NOTHING COULD CHEER YOU UP at their WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, how much did FEELING THAT NOTHING COULD CHEER YOU UP INTERFERE with your usual or daily activities?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

In the last 30 days, how OFTEN did you have SAD OR UNHAPPY FEELINGS?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Almost constantly

In the last 30 days, what was the SEVERITY of your SAD OR UNHAPPY FEELINGS at their WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, how much did SAD OR UNHAPPY FEELINGS INTERFERE with your usual or daily activities?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

Oral

In the last 30 days, what was the SEVERITY of your DRY MOUTH at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, what was the SEVERITY of your DIFFICULTY SWALLOWING at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, what was the SEVERITY of your MOUTH OR THROAT SORES at their WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, how much did MOUTH OR THROAT SORES INTERFERE with your usual or daily activities?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

In the last 30 days, what was the SEVERITY of SKIN CRACKING AT THE CORNERS OF YOUR MOUTH at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, did you have any VOICE CHANGES?

☐ No ☐ Yes

In the last 30 days, what was the SEVERITY of your HOARSE VOICE at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

Respiratory

In the last 30 days, what was the SEVERITY of your SHORTNESS OF BREATH at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, how much did your SHORTNESS OF BREATH INTERFERE with your usual or daily activities?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

In the last 30 days, what was the SEVERITY of your COUGH at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, how much did COUGH INTERFERE with your usual or daily activities?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

In the last 30 days, what was the SEVERITY of your WHEEZING (WHISTLING NOISE IN THE CHEST WITH BREATHING) at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

Cardio / Circulatory

In the last 30 days, how OFTEN did you have ARM OR LEG SWELLING?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Almost constantly

In the last 30 days, what was the SEVERITY of your ARM OR LEG SWELLING at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, how much did ARM OR LEG SWELLING INTERFERE with your usual or daily activities?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

In the last 30 days, how OFTEN did you feel a POUNDING OR RACING HEARTBEAT (PALPITATIONS)?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Almost constantly

In the last 30 days, what was the SEVERITY of your POUNDING OR RACING HEARTBEAT (PALPITATIONS) at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

Cutaneous

In the last 30 days, did you have any RASH?

☐ No ☐ Yes

In the last 30 days, what was the SEVERITY of your DRY SKIN at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, what was the SEVERITY of your ACNE OR PIMPLES ON THE FACE OR CHEST at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, did you have any HAIR LOSS?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

In the last 30 days, what was the SEVERITY of your ITCHY SKIN at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, did you have any HIVES (ITCHY RED BUMPS ON THE SKIN)?

☐ No ☐ Yes

In the last 30 days, what was the SEVERITY of your HAND-FOOT SYNDROME (A RASH OF THE HANDS OR FEET THAT CAN CAUSE CRACKING, PEELING, REDNESS OR PAIN) at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, did you LOSE ANY FINGERNAILS OR TOENAILS?

☐ No ☐ Yes

In the last 30 days, did you have any RIDGES OR BUMPS ON YOUR FINGERNAILS OR TOENAILS?

☐ No ☐ Yes

In the last 30 days, did you have any CHANGE IN THE COLOUR OF YOUR FINGERNAILS OR TOENAILS?

☐ No ☐ Yes

In the last 30 days, did you have any INCREASED SKIN SENSITIVITY TO SUNLIGHT?

☐ No ☐ Yes

In the last 30 days, did you have any BED SORES?

☐ No ☐ Yes

In the last 30 days, what was the SEVERITY of your SKIN BURNS FROM RADIATION at their WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe ☐ Not applicable

In the last 30 days, did you have any UNUSUAL DARKENING OF THE SKIN?

☐ No ☐ Yes

In the last 30 days, did you have any STRETCH MARKS?

☐ No ☐ Yes

Visual / Perceptual

In the last 30 days, what was the SEVERITY of your BLURRY VISION at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, how much did BLURRY VISION INTERFERE with your usual or daily activities?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

In the last 30 days, did you have any FLASHING LIGHTS IN FRONT OF YOUR EYES?

☐ No ☐ Yes

In the last 30 days, did you have any SPOTS OR LINES (FLOATERS) THAT DRIFT IN FRONT OF YOUR EYES?

☐ No ☐ Yes

In the last 30 days, what was the SEVERITY of your WATERY EYES (TEARING) at their WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, how much did WATERY EYES (TEARING) INTERFERE with your usual or daily activities?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

In the last 30 days, what was the SEVERITY of RINGING IN YOUR EARS at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

Urinary

In the last 30 days, what was the SEVERITY of your PAIN OR BURNING WITH URINATION at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, how OFTEN did you feel an URGE TO URINATE ALL OF A SUDDEN?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Almost constantly

In the last 30 days, how much did SUDDEN URGES TO URINATE INTERFERE with your usual or daily activities?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

In the last 30 days, were there times when you had to URINATE FREQUENTLY?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Almost constantly

In the last 30 days, how much did FREQUENT URINATION INTERFERE with your usual or daily activities?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

In the last 30 days, did you have any URINE COLOUR CHANGE?

☐ No ☐ Yes

In the last 30 days, how OFTEN did you have LOSS OF CONTROL OF URINE (LEAKAGE)?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Almost constantly

In the last 30 days, how much did LOSS OF CONTROL OF URINE (LEAKAGE) INTERFERE with your usual or daily activities?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

Other Symptoms

In the last 30 days, what was the SEVERITY of your BREAST AREA ENLARGEMENT OR TENDERNESS at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, did you BRUISE EASILY (BLACK AND BLUE MARKS)?

☐ No ☐ Yes

In the last 30 days, how OFTEN did you have SHIVERING OR SHAKING CHILLS?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Almost constantly

In the last 30 days, what was the SEVERITY of your SHIVERING OR SHAKING CHILLS at their WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, how OFTEN did you have UNEXPECTED OR EXCESSIVE SWEATING DURING THE DAY OR NIGHT TIME (NOT RELATED TO HOT FLASHES)?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Almost constantly

In the last 30 days, what was the SEVERITY of your UNEXPECTED OR EXCESSIVE SWEATING DURING THE DAY OR NIGHT TIME (NOT RELATED TO HOT FLASHES) at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, did you have an UNEXPECTED DECREASE IN SWEATING?

☐ No ☐ Yes

In the last 30 days, how OFTEN did you have HOT FLASHES?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Almost constantly

In the last 30 days, what was the SEVERITY of your HOT FLASHES at their WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, how OFTEN did you have NOSEBLEEDS?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Almost constantly

In the last 30 days, what was the SEVERITY of your NOSEBLEEDS at their WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, did you HAVE ANY PAIN, SWELLING, OR REDNESS AT A SITE OF DRUG INJECTION OR IV?

☐ No ☐ Yes ☐ Not applicable

In the last 30 days, what was the SEVERITY of your BODY ODOUR at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

Do you have any other symptoms that you wish to report?

☐ No ☐ Yes

Please list any other symptoms

1.	In the last 30 days, what was the SEVERITY of this symptom at its WORST? ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe
2.	In the last 30 days, what was the SEVERITY of this symptom at its WORST? ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe
3.	In the last 30 days, what was the SEVERITY of this symptom at its WORST? ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe
4.	In the last 30 days, what was the SEVERITY of this symptom at its WORST? ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe
5.	In the last 30 days, what was the SEVERITY of this symptom at its WORST? ☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very sever

FEMALE ONLY QUESTIONS

In the last 30 days, did you have any IRREGULAR MENSTRUAL PERIODS?

☐ No ☐ Yes ☐ Not applicable

In the last 30 days, did you MISS AN EXPECTED MENSTRUAL PERIOD?

☐ No ☐ Yes ☐ Not applicable

In the last 30 days, did you have any UNUSUAL VAGINAL DISCHARGE?

☐ Not at all ☐ A little bit ☐ Somewhat ☐ Quite a bit ☐ Very much

In the last 30 days, what was the SEVERITY of your VAGINAL DRYNESS at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

In the last 30 days, what was the SEVERITY of your DECREASED SEXUAL INTEREST at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe

In the last 30 days, did you feel that it TOOK TOO LONG TO HAVE AN ORGASM OR CLIMAX?

☐ No ☐ Yes ☐ Not sexually active ☐ Prefer not to answer

In the last 30 days, were you UNABLE TO HAVE AN ORGASM OR CLIMAX?

☐ No ☐ Yes ☐ Not sexually active ☐ Prefer not to answer

In the last 30 days, what was the SEVERITY of your PAIN DURING VAGINAL SEX at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe ☐ Not sexually active ☐ Prefer not to answer

MALE ONLY QUESTIONS

In the last 30 days, what was the SEVERITY of your DIFFICULTY GETTING OR KEEPING AN ERECTION at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe ☐ Not sexually active ☐ Prefer not to answer

In the last 30 days, how OFTEN did you have EJACULATION PROBLEMS?

☐ Never ☐ Rarely ☐ Occasionally ☐ Frequently ☐ Almost constantly ☐ Not sexually active ☐ Prefer not to answer

In the last 30 days, what was the SEVERITY of your DECREASED SEXUAL INTEREST at its WORST?

☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ Very severe ☐ Not sexually active ☐ Prefer not to answer

Please provide below any further comments or feedback you would like to give to the Day Oncology Unit