LENT / SOMA PATIENT QUESTIONNAIRE

ID No: _____

Date Completed: _____

(PLEASE ANSWER QUESTIONS AS TO HOW YOU'VE BEEN FEELING OVER THE LAST 2 WEEKS ONLY, BY CIRCLING THE APPROPRIATE ANSWER)

Have you had any pain in your breast recently?

0 = None
1 = Rarely
2 = Sometimes
3 = Often
4 = Always

If Yes, how severe is the pain?

1 = Minimal
2 = Tolerable
3 = Intense
4 = Excruciating

Are you taking any medication for this pain?

0 = No
1 = Yes

If Yes, please give name of medication & how often you take this

_____

_____

Has the feeling in your skin changed where you were treated?

0 = Not at all
1 = Yes, it itches and is sensitive
2 = Yes, it is painful sometimes
3 = Yes, it is painful regularly
4 = Yes, it is painful constantly

Would you like any of the issues raised in these questionnaires to be brought to the attention of your treating team?

⑨ **No** ⑨ **Yes**

Many Thanks for completing this questionnaire.