LENT / SOMA PATIENT QUESTIONNAIRE

ID No: _____

Date Form Completed: _____

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

Do you have any pain?

1. 0 = Not at all
   1 = In your Ears - Yes / No
   2 = In your Teeth - Yes / No
   3 = In your Jaw - Yes / No
   4 = In your Mouth - Yes / No
   5 = In your Throat - Yes / No

If you have answered **YES** to any of the above please answer the following questions.

2. How severe was the pain in your **Ears?**
   1 = Minimal
   2 = Tolerable
   3 = Intense
   4 = Excruciating

3. How often have you had pain in your **Ears?**
   1 = Occasionally
   2 = Sometimes
   3 = Often
   4 = Always

4. Are you taking any medication for the pain in your **Ears?**
   0 = No
   1 = Yes, occasionally
   2 = Yes, regularly

5. If yes, please give name of medication
   _____

6. How severe was the pain in your **Teeth?**
   1 = Minimal
   2 = Tolerable
   3 = Intense
   4 = Excruciating

7. How often have you had pain in your **Teeth?**
   1 = Occasionally
   2 = Sometimes
   3 = Often
   4 = Always

8. Are you taking any medication for the pain in your **Teeth?**
   0 = No
   1 = Yes, occasionally
   2 = Yes, regularly

9. If yes, please give name of medication
   _____

10. How severe was the pain in your **Jaw?**
    1 = Minimal
    2 = Tolerable
    3 = Intense
    4 = Excruciating

11. How often have you had pain in your **Jaw?**
    1 = Occasionally
    2 = Sometimes
    3 = Often
    4 = Always

12. Are you taking any medication for the pain in your **Jaw?**
    0 = No
    1 = Yes, occasionally
    2 = Yes, regularly

13. If yes, please give name of medication
    _____

(**PLEASE CIRCLE THE APPROPRIATE ANSWER)**

14. How severe was the pain in your **Mouth?**
1 = Minimal
2 = Tolerable
3 = Intense
4 = Excruciating

15. How often have you had pain in your **Mouth?**
1 = Occasionally
2 = Sometimes
3 = Often
4 = Always

16. Are you taking any medication for the pain in your **Mouth?**
0 = No
1 = Yes, occasionally
2 = Yes, regularly

17. If yes, please give name of medication

_____

18. How severe was the pain in your **Throat?**
1 = Minimal
2 = Tolerable
3 = Intense
4 = Excruciating

19. How often have you had pain in your **Throat?**
1 = Occasionally
2 = Sometimes
3 = Often
4 = Always

20. Are you taking any medication for the pain in your **Throat?**
0 = No
1 = Yes, occasionally
2 = Yes, regularly

21. If yes, please give name of medication

_____

22. Please state what your weight is at the moment

_____

23. How often is your mouth dry?
0 = Not at all
1 = Rarely
2 = Sometimes
3 = Often

24. Does this affect you severely?
0 = No
1 = Yes

25. Do you have any trouble chewing?
0 = Not at all
1 = With solid food
2 = With soft food

26. Do you have any trouble swallowing?
0 = Not at all
1 = With solid food
2 = With soft food
3 = Only able to swallow liquids
4 = Unable to swallow

27. Do you wear dentures?
0 = No
1 = Yes

28. If Yes, do you have any difficulty with your dentures?
0 = No
1 = Loose
2 = Can't wear

(**PLEASE CIRCLE THE APPROPRIATE ANSWER)**

29. Do you have any trouble opening your mouth?
- 0 = No
- 1 = Yes, A little
- 2 = Yes, I have trouble eating normally
- 3 = Yes, I have a lot of difficulty eating normally
- 4 = Yes, I cannot eat

30. Has your sense of taste changed?
- 0 = Not at all
- 1 = Mildly
- 2 = Moderate
- 3 = Severe / Unable to taste anything

31. Is your voice hoarse?
- 0 = Not at all
- 1 = A little
- 2 = Can sometimes vary
- 3 = Yes all the time
- 4 = Unable to speak

32. Do you have any trouble breathing?
- 0 = Not at all
- 1 = Rarely
- 2 = Sometimes
- 3 = Always difficult

33. Is your breathing noisy?
- 0 = No
- 1 = Yes

34. In the past 2 weeks has your skin been rough or flaky in the area where you have been treated?
- 0 = Not at all
- 1 = Yes, but it feels normal
- 2 = It feels different but I've not not treated it
- 3 = Yes, I'm treating it at the moment

35. Has the feeling in your skin changed?
- 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

36. Do you have any ringing in you ears?
- 0 = Not at all
- 1 = Rarely
- 2 = Sometimes
- 3 = Often
- 4 = Always

37. Have you had any hearing loss recently?
- 0 = No
- 1 = Yes

(**PLEASE CIRCLE THE APPROPRIATE ANSWER)**

38. If Yes, how severe is this?

1 = Minor
2 = Frequent difficulty with faint speech
3 = Frequent difficulty with loud speech
4 = Complete deafness

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

☐ **No** ☐ **Yes**

Many Thanks for completing this questionnaire.