PATIENT QUESTIONNAIRE

1. **PLEASE COMPLETE YOUR DATE OF BIRTH (MONTH & YEAR ONLY) AND TODAY'S DATE**
2. **PLEASE ANSWER THE QUESTIONS AS TO HOW YOU'VE BEEN FEELING OVER THE LAST 2 WEEKS BY TICKING THE BOX NEXT TO THE APPROPRIATE ANSWER**

Study Number ☐☐☐☐☐☐☐

Patient Initials ☐☐☐☐

Date of Birth (mmyyyy) X X / m m / y y y y

Date completed (ddmmyyyy) d d / m m / y y y y

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

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Does the pain interfere with your normal daily activities?

- ☐ 0 = No
- ☐ 1 = Yes

Do you have a swollen arm?

- ☐ 0 = No
- ☐ 1 = Yes

If Yes,

- ☐ 1 = Only on side of treatment
- ☐ 2 = Both arms

Does your swollen arm interfere with normal activity?

- ☐ 0 = No
- ☐ 3 = Yes
- ☐ 8 = Not applicable

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 this questionnaire to be brought to the attention of your treating team?

- ☐ 0 = No
- ☐ 1 = Yes

Many thanks for completing this questionnaire.