Head and Neck Radiotherapy Patient Questionnaire (LATE TOXICITY)

Patient initials ☐☐☐☐

Date of Birth (ddmmyy) ☐☐☐☐☐☐

Date completed ☐☐☐☐☐☐

Please answer the questions as to how you've have been feeling over the last **2 WEEKS**

The next few questions are about pain in your HEAD and NECK only: **Please fill box:**

1. How severe is the pain?
   0 = None
   1 = Mild
   2 = Moderate
   3 = Severe ☐

2. Where is the pain? *(tick all that apply)*
   1 = Mouth ☐
   2 = Throat ☐
   3 = Jaw ☐
   4 = Neck ☐
   5 = Skin ☐
   6 = Ear ☐
   7 = Others, *please state*: ☐
   _____

3. Are you taking any medication for this pain?
   0 = No
   1 = Yes, occasionally
   2 = Yes, regularly ☐

4. If Yes, please give name of medication and how often:
   _____
   _____

5. Does the pain or painkillers interfere with daily self care activities (see bottom of page)*?
   0 = No
   3 = Yes ☐

The next few questions are about your mouth or eating:

6. Have you lost your appetite?
   0 = No
   1 = Yes ☐

7. Have you had difficulties in swallowing?
   0 = No
   1 = Yes ☐

8. Have you any difficulty opening your mouth?
   0 = No
   1 = Yes ☐

9. Do you have any alteration in your taste?
   0 = None
   1 = Yes ☐

10. If Yes, have you had any loss of taste and / or do you find taste unpleasant?
    1 = No
    2 = Yes ☐

11. Have you had a dry mouth?
    0 = No
    1 = Yes ☐

12. Have you had any changes to your saliva?
    0 = None
    1 = Yes, it's slightly thickened
    2 = Yes, it's ropey, thick and sticky ☐

*Eg. bathing, getting about indoors, dressing, getting in / out of bed

13. If Yes, has it affected your taste?
    0 = No
    1 = Yes, slightly
    2 = Yes, markedly

14. If you have saliva changes, how has it affected your daily self care activities*?
    0 = Not at all
    3 = Interferes with self care activities
    4 = Unable to self care

15. Has your diet been significantly affected?
    0 = Normal regular diet
    1 = Yes, but can manage solid food
    2 = Yes, mostly soft or liquidised food
    3 = Cannot eat / swallow adequately or need fluid drip / tube feeding

16. If your diet has been significantly affected, what has caused it? *(tick all that apply)*
    1 = Difficulty in swallowing
    2 = Dry mouth
    3 = Difficulty opening mouth
    4 = Loss of appetite
    5 = Altered taste
    6 = Change in saliva
    7 = Others, *please state:* _____

17. If you are on supplementary nutritional drinks, why are you requiring them? *(tick all that apply)*
    0 = Not on supplementary drinks
    1 = Difficulty in swallowing
    2 = Weight loss
    3 = Loss of appetite
    4 = Altered taste
    5 = Others, *please state:* _____

The next few questions are about your skin <u>in the area treated with radiotherapy:</u>

18. Have you any visible roughness or flaking of your skin?
    0 = No
    1 = Yes

19. If Yes, how obvious is it?
    1 = Only close-up
    2 = Easily apparent

20. If Yes, does this affect your appearance?
    1 = No
    3 = Yes
    3 = Would like surgery if feasible

21. Have you any thickening or hardening of your skin (skin fibrosis)?
    0 = No
    1 = Yes

22. If Yes, how severe is the skin thickening / hardening?
    1 = Mild
    2 = Marked
    3 = Interferes with self care activities

23. Have you any skin itchiness?
    0 = No
    1 = Mild and localised
    2 = Intense or widespread
    3 = Interferes with self care activities

24. Do you have any puffiness in your head and neck?
    0 = No
    1 = Yes

25. If Yes, has it interfered with any function (eg. turning your head or opening mouth) compared with before radiotherapy?
    0 = No
    2 = Yes

*Eg. bathing, getting about indoors, dressing, getting in / out of bed

The next few questions are about your voice:

26. Are you getting any hoarseness / voice changes?
    0 = None
    1 = Yes, intermittently
    2 = Yes, persistently
    8 = Voice box has been removed (laryngectomy)
    ☐

27. If you have hoarseness / voice change, how severe is it?
    1 = Mild
    2 = Moderate
    3 = Severe and predominantly whispered speech
    4 = Complete loss of voice
    ☐

28. Can your voice be understood?
    1 = Fully understandable
    2 = Needs occasional repetition but understandable on phone
    3 = Needs frequent repetition or face to face contact to understand
    4 = Non-understandable, requires voice aid machine or writing (>50% of time for communication)
    ☐

The next few questions are about your hearing:

29. Have you had any hearing loss?
    0 = No
    1 = Yes
    ☐

30. If Yes, how severe has this been?
    1 = Minor
    2 = Frequent difficulty with faint speech
    3 = Frequent difficulty with loud speech
    4 = Complete deafness
    ☐

31. Do you require a hearing aid?
    1 = No
    2 = Yes
    ☐

32. Are you getting any noise or ringing in your ears?
    0 = No
    1 = Yes, rarely
    2 = Yes, sometimes
    3 = Yes, often
    ☐

33. If Yes, how has it affected your daily self care activities* ?
    2 = Not at all
    3 = Interferes with self care activities
    4 = Cannot self care
    ☐

*Eg. bathing, getting about indoors, dressing, getting in / out of bed

Please bring the above symptoms to the attention of your doctor should you wish to discuss them further.

Many thanks for completing this questionnaire.