South-East London Cancer Network / Department of Ageing and Health
Guy's and St Thomas' NHS Foundation Trust

NAME	DOB
Date	

In the previous 12 months have you been admitted to a hospital?

Not at all ☐

1 -2 times ☐

3 or more times ☐

Don't know ☐

Do you have diabetes?

I do not have diabetes ☐

My diabetes control is usually good (blood sugars below 10) ☐

My diabetes is usually fair (blood sugars 10 or above) ☐

Don't know ☐

Is your blood pressure generally high when the doctor or nurse checks it?

No ☐

Yes ☐

Don't know ☐

Do you suffer from angina or have you ever had a heart attack?

No ☐

Yes ☐

Don't know ☐

Have you ever had a stroke?

No ☐

Yes ☐

Don't know ☐

Do you have chronic lung problems?

No ☐

Yes ☐

Don't know ☐

Do you get short of breath walking on flat surfaces?

No ☐

Yes ☐

Don't know ☐

Have you had 1 or more falls from standing or sitting over the past 6 months?

No ☐

Yes ☐

Don't know ☐

Do you have significant memory problems?

No ☐

Yes ☐

Don't know ☐

Have you ever had episodes of feeling confused?

No ☐

Yes ☐

Don't know ☐

Do you have poor vision that limits what you can do?

No ☐

Yes ☐

Don't know ☐

Over the past month have you needed more help than usual to take care of yourself?

No ☐

Yes ☐

Don't know ☐

Do you have difficulty with any of the following?

	Not at all	A little	Quite a bit	A lot
Bathing yourself	☐	☐	☐	☐
Climbing stairs	☐	☐	☐	☐
Getting to the toilet	☐	☐	☐	☐
Moving from bed to chair or standing up	☐	☐	☐	☐
Dressing yourself	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Driving	☐	☐	☐	☐
Taking public transport	☐	☐	☐	☐
Shopping for food	☐	☐	☐	☐
Managing financial affairs	☐	☐	☐	☐

Is there a friend, relative or neighbour who would take care of you for a few days if necessary?

No ☐

Yes ☐

Don't know ☐

Is there a friend or relative you feel you can talk to about your cancer and cancer treatment?

No ☐

Yes ☐

Don't know ☐

What is your living situation?

Live alone ☐

Live with partner ☐

Live with someone other than partner ☐

Live in sheltered housing ☐

Are you a caregiver for someone who depends on you?

No ☐

Yes ☐ Who? _________________

In the past year have you had urinary leakage that has bothered you?

No ☐

Yes ☐

Don't know ☐

Have you lost weight or been eating less in last 6 months?

No ☐

Yes ☐

Don't know ☐

Please list the names of ALL the medications that you are taking

Don't know ☐

Do you think you are having any symptoms due to your medications?

No ☐

Yes ☐

Don't know ☐

Are there any other problems that you would like to tell us about?

THANK YOU

This information will help keep track of how you feel and how well you are able to do your usual activities.

1. Have you had any treatment for your cancer this month?		
	Yes	**No**
If yes, what kind of treatment did you have? (Please tick all that apply)		
Chemotherapy	Radiotherapy	Surgery
Other (please specify)		

2. What kind of formal practical support did you get this month? (This is support provided to you by an agency, a service or a paid carer)			
Transport to the hospital	Help shopping	Help around the house	Financial support or advice
Handyperson/ DIY	Gardening	Emotional support	Exercise group
Other (please specify)			

3. Please rate overall the formal support you have received.					
	Excellent	**Very Good**	**Good**	**Fair**	**Poor**
Please tick the one box that best describes your answer					
Any other comments? (Was there any support or person that was particularly helpful or unhelpful?)					

4. What kind of support did you get this month from friends, family, neighbors etc?			
Transport to the hospital	Help shopping	Help around the house	Financial support or advice
Handyman/DIY	Gardening	Emotional support	Exercise group
Other (please specify)			

5. Is there any practical support that you would have found helpful that you <u>did not</u> receive?		
	Yes	**No**

Thank you

[2] EORTC QLQ C30 (V3) - Validated quality of life questionnaire –

We are interested in some things about you and your health. Please answer all of the questions yourself by circling the number that best applies to you. There are no "right" or "wrong" answers.

	Not at all	A little	Quite a bit	Very much
1. Do you have any trouble doing strenuous activities like carrying a heavy shopping bag or a suitcase	1	2	3	4
2. Do you have any trouble taking a long walk?	1	2	3	4
3. Do you have any trouble taking a short walk outside of the house?	1	2	3	4
4. Do you need to stay in bed or a chair during the day?	1	2	3	4
5. Do you need help with eating, dressing, washing yourself or using the toilet?	1	2	3	4

During the past week:

6. Were you limited in doing either your work or other daily activities?	1	2	3	4
7. Were you limited in pursuing your hobbies or other leisure time activities?	1	2	3	4
8. Were you short of breath?	1	2	3	4
9. Have you had pain?	1	2	3	4
10. Did you need to rest?	1	2	3	4
11. Have you had trouble sleeping?	1	2	3	4
12. Have you felt weak?	1	2	3	4
13. Have you lacked appetite?	1	2	3	4
14. Have you felt nauseated?	1	2	3	4
15. Have you vomited?	1	2	3	4
16. Have you been constipated?	1	2	3	4
17. Have you had diarrhoea?	1	2	3	4
18. Were you tired?	1	2	3	4
19. Did pain interfere with your daily activities	1	2	3	4

20. Have you had difficulty in concentrating on things, like reading a newspaper or watching television?	1	2	3	4
21. Did you feel tense?	1	2	3	4

During the past week:

22. Did you worry?	1	2	3	4
23. Did you feel irritable?	1	2	3	4
24. Did you feel depressed?	1	2	3	4
25. Have you had difficulty remembering things?	1	2	3	4
26. Has your physical condition or medical treatment interfered with your family life?	1	2	3	4
27. Has your physical condition or medical treatment interfered with your social activities?	1	2	3	4
28. Has your physical condition or medical treatment caused you financial difficulties?	1	2	3	4

For the following questions please circle the number between 1 and 7 that best applies to you

29. How would you rate your overall health during the past week?

1 2 3 4 5 6

Very poor Excellent

30. How would you rate your overall quality of life during the past week?

1 2 3 4 5 6

Very poor Excellent

Did you need someone to assist you in completing this questionnaire?

No ☐

Yes ☐

About how long did it take you to complete the questionnaire?

___________ minutes

Don't know ☐

THANK YOU