Questionnaire

Name:

Patient ID number

Date:

Guide:

How to fill in the questionnaire:

1) Use a pen

2) Please, read every question and all the categories of answer to that question before you answer. Pay attention that sometimes you may tick off more than one box. If more than one tick off is allowed, it will be listed as follows: ”(Please tick off more than one box if relevant)”. Tick off the statement most in harmony with your opinion. If you make a mistake or change your mind, fill out the whole wrong box and tick off the new box.

3) Some questions are easier than others to answer. If you are in doubt, tick off the box most appropriate for you. If there are questions you are not able to or do not want to answer, then please continue to the next question.

4) Please, fill in the questionnaire according to how ***you have been feeling about yourself during the past week***.

In this questionnaire we understand pain as just something hurting. We do not distinguish between pain and something hurting.

The questionnaire is divided into the following groups of questions:

- General
- Questions regarding pain
- Questions regarding sensory disturbances or discomfort
- Questions regarding swelling and heaviness (lymph edema)
- Questions regarding restriction of function

DBCG – SKAGEN TRIAL 1

DANISH BREAST CANCER COOPERATIVE GROUP

PATIENT FORM

MORBIDITY, BIS

Name – Patient ID	Hospital
Day - Month - Year - No.	
Years after RT 0 1 2 3 4 5 10	Date ddmmyy

Patient reported morbidity

	None	Sometimes	Often	Always
Pain, breast / chest wall				

	None	Sometimes, mild	Often, mild	Opiod need
Analgesics because of pain in breast / chest wall				

	None	Slight	Moderate	Severe
Sensibility changes, breast / chest wall				

	High confidence	Feels less confidence, less feminine	Lack of confidence, avoids mirrors	Ashamed of body
Body image				

	No	Yes
Dresses differently, e.g. prefers looser fitting clothing		

Body Image Scale

	Not at all	A little	Quite a bit	Very much
Have you been feeling self-conscious about your appearance?				
Have you felt less physically attractive as a result of your disease or treatment?				
Have you been dissatisfied with your appearance when dressed?				
Have you been feeling less feminine/masculine as a result of your disease or treatment?				
Did you find it difficult to look at yourself naked?				
Have you been feeling less sexually attractive as a result of your disease or treatment?				
Did you avoid people because of the way you felt about your appearance?				
Have you been feeling the treatment has left your body less whole?				
Have you felt dissatisfied with your body?				
Have you been dissatisfied with the appearance of your scar?				

	Poor	Fair	Good	Excellent
How satisfied are you with the overall result of your treated breast?				
How satisfied are you with the overall result of your treated breast compared to the other breast? (Only relevant after breast conserving surgery.)				

	No	Yes
Have you had lipo injection in your treated breast / chest wall since last follow up visit?		
Have you had lipo injection in your opposite breast since last follow up visit?		

DBCG – SKAGEN TRIAL 1

DANISH BREAST CANCER COOPERATIVE GROUP

PATIENT FORM

QUESTIONNAIRE

Name – Patient ID	Hospital
Day - Month - Year - No.	
Years after RT 0 1 2 3 4 5 10	Date ddmmyy

	Right-handed	Left-handed
1. Are you right-handed or left-handed?		

Questions regarding pain

In this questionnaire we define "breast area" as either the operated breast or the area from which the breast was removed.

	No	Yes
2. Do you have pain in the area of the breast, armpit, side of the body or the arm on the side where you had surgery? If "No", please proceed to question 12 (next page).		
3. If "Yes", where do you have pain? (Please, tick yes or no for each area)		
Area of the breast		
The side of the body		
Armpit		
Arm		

	0	1	2	3	4	5	6	7	8	9	10
4. If you have pain in the **area of the breast**, how strong on average is the pain? (0 is no pain and 10 is the worst pain imaginable)											

	(Almost) every day	1-3 days a week	More rarely
5. If you have pain in the area of the breast, how often do you have this pain?			

	0	1	2	3	4	5	6	7	8	9	10
6. If you have pain on the **side of the body**, how strong on average is the pain?											

	(Almost) every day	1-3 days a week	More rarely
7. If you have pain on the side of the body, how often do you have this pain?			

	0	1	2	3	4	5	6	7	8	9	10
8. If you have pain in the **armpit**, how strong on average is the pain?											

	(Almost) every day	1-3 days a week	More rarely
9. If you have pain in the armpit, how often do you have this pain?			

	0	1	2	3	4	5	6	7	8	9	10
10. If you have pain in the **arm**, how strong on average is the pain?											

	(Almost) every day	1-3 days a week	More rarely
11. If you have pain in the arm, how often do you have this pain?			

Patient ID ☐☐ - ☐☐ - ☐☐ - ☐☐☐☐
Day Month Year No.

Questions regarding sensory disturbances or discomfort

	No	Yes
12. Do you have sensory disturbances or discomfort in the area of the breast, armpit, side of the body or the arm on the side where you had surgery? If ”No”, please proceed to question 14.		
13. If ”Yes”, where do you have sensory disturbances or discomfort? (Please, tick yes or no for each area)		
Area of the breast		
The side of the body		
Armpit		
Arm		

Questions regarding swelling and heaviness (lymphedema)

	No	Yes
14. Does the armpit, the arm or the back of the hand, on the side where you had surgery, sometimes or always feel swollen or heavy? If ”No”, please proceed to question 19.		
15. If ”Yes”, where do you feel the armpit, arm or back of the hand is swollen or heavy? (Please, tick yes or no for each area)		
Back of the hand		
Forearm		
Upper arm		
Armpit		

	0	1	2	3	4	5	6	7	8	9	10
16. How severe are the swellings/sensation of heaviness of your armpit and/or upper arm? (0 is no swellings/sensation of heaviness and 10 is the worst imaginable swellings/sensation of heaviness)											
17. How severe are the swellings/sensation of heaviness of your forearm and/or back of your hand?											

	(Almost) every day	1-3 days a week	More rarely
18. How often does the swellings/sensation of heaviness occur?			

Questions regarding restriction of function

How do you manage the following activities compared with before your treatment for breast cancer? (Select “Not relevant” for activities you do not perform.)

	The same way as before	The same way as before, but with difficulties/slower and/or more tired afterwards	The same way as before, but with more pain afterwards	In another way than before, for example using the other arm/both hands	Not relevant
19. Washing hair					
20. Brushing teeth					
21. Taking a bra off/on					
22. Carrying shopping bags					
23. Lifting above the height of shoulders					
24. Cleaning floors					