Study number: | | | **TOX** | | | | |

headandneck 5000

Head and Neck Radiotherapy Questionnaire (LATE TOXICITY)

Your Symptoms

*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:

L1 **How severe is the pain?**

- None ☐ 1
- Mild ☐ 2
- Moderate ☐ 3
- Severe ☐ 4

L2 **Where is the pain? *(tick all that apply)***

- Mouth ☐ 1
- Throat ☐ 2
- Jaw ☐ 3
- Neck ☐ 4
- Skin ☐ 5
- Ear ☐ 6
- Others ☐ 7 Please state: _____

L3 **Are you taking any medication for this pain?**

- No ☐ 1
- Yes, occasionally ☐ 2
- Yes, regularly ☐ 3

L4 **If Yes, please give name of medication and how often**

Medication	How often
_____	_____
_____	_____

L5 **Does the pain or painkillers interfere with daily self care activities (see bottom of page)*?**

- No ☐ 1
- Yes ☐ 2

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

The next few questions are about your mouth or eating:

L6 Have you lost your appetite'?

- No ☐ 1
- Yes ☐ 2

L7 Have you had difficulties in swallowing?

- No ☐ 1
- Yes ☐ 2

L8 Have you any difficulty opening your mouth?

- No ☐ 1
- Yes ☐ 2

L9 Do you have any alteration in your taste?

- No ☐ 1
- Yes ☐ 2

L10 If Yes, have you had any loss of taste and *I* or do you find taste unpleasant?

- No ☐ 1
- Yes ☐ 2

L11 Have you had a dry mouth?

- No ☐ 1
- Yes ☐ 2

L12 Have you had any changes to your saliva?

- None ☐ 1
- Yes, it's slightly thickened ☐ 2
- Yes, it's ropey, thick and sticky ☐ 3

L13 If Yes, has it affected your taste?

- No ☐ 1
- Yes, slightly ☐ 2
- Yes, markedly ☐ 3

L14 If you have saliva changes, how has it affected your daily self care activities*?

Not at all ☐ 1

Interferes with self care activities ☐ 2

Unable to self care ☐ 3

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

L15 Has your diet been significantly affected?

Normal regular diet ☐ 1

Yes, but can manage solid food ☐ 2

Yes, mostly soft or liquidised food ☐ 3

Cannot eat I swallow adequately or need fluid drip / tube feeding ☐ 4

L16 If your diet has been significantly affected, what has caused it? *(tick all that apply)*

Difficulty in swallowing ☐ 1

Dry mouth ☐ 2

Difficulty opening mouth ☐ 3

Loss of appetite ☐ 4

Altered taste ☐ 5

Change in saliva ☐ 6

Others ☐ 7 Please state: _____

L17 If you are on supplementary nutritional drinks, why are you requiring them? *(tick all that apply)*

Not on supplementary drinks ☐ 1

Difficulty in swallowing ☐ 2

Weight loss ☐ 3

Loss of appetite ☐ 4

Altered taste ☐ 5

Others ☐ 6 Please state: _____

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

L18 Have you any visible roughness or flaking of your skin

No ☐ 1

Yes ☐ 2

L19 If Yes, how obvious is it?

Only close-up ☐ 1

Easily apparent ☐ 2

L20 If Yes, does this affect your appearance?

No ☐ 1

Yes ☐ 2

Would like surgery if feasible ☐ 3

L21 Have you any thickening or hardening of your skin (skin fibrosis)?

No ☐ 1

Yes ☐ 2

L22 If Yes, how severe is the skin thickening / hardening?

Mild ☐ 1

Marked ☐ 2

Interferes with self care activities ☐ 3

L23 Have you any skin itchiness?

No ☐ 1

Mild and localised ☐ 2

Intense or widespread ☐ 3

Interferes with self care activities ☐ 4

L24 Do you have any puffiness in your head and neck?

No ☐ 1

Yes ☐ 2

L25 If Yes, has it interfered with any function (eg turning your head or opening mouth) compared with before radiotherapy?

No ☐ 1

Yes ☐ 2

The next few questions are about your voice:

L26 Are you getting any hoarseness / voice changes?

- None ☐ 1
- Yes, intermittently ☐ 2
- Yes, persistently ☐ 3
- Voice box has been removed (laryngectomy) ☐ 4

L27 If you have hoarseness / voice change, how severe is it?

- Mild ☐ 1
- Moderate ☐ 2
- Severe and predominantly whispered speech ☐ 3
- Complete loss of voice ☐ 4

L28 Can your voice be understood?

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

The next few questions are about your hearing:

L29 Have you had any hearing loss?

- No ☐ 1
- Yes ☐ 2

L30 If Yes, how severe has this been?

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

L31 Do you require a hearing aid?

- No ☐ 1
- Yes ☐ 2

L32 Are you getting any noise or ringing in your ears?

- No ☐ 1
- Yes, rarely ☐ 2
- Yes, sometimes ☐ 3
- Yes, often ☐ 4

L33 If Yes, how has it affected your daily self care activities* ?

- Not at all ☐ 1
- Interferes with self care activities ☐ 2
- Cannot self care ☐ 3

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

Thank you for completing the questionnaire