Study-ID: GB - __ __ __ - __ __ __

EORTC QLQ-C30 (version 3)

Date:

We are interested in some things about you and your health. Please answer all of the questions yourself by indicating the number that best applies to you. There are no "right" or "wrong" answers. The information that you provide will remain strictly confidential.

		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:

		Not at All	A Little	Quite a Bit	Very Much
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

Please go on to the next page

During the past week:	Not at All	A Little	Quite a Bit	Very Much
17. Have you had diarrhea?	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
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	7
Very poor						Excellent

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

1	2	3	4	5	6	7
Very poor						Excellent

AXSANA-Study

Study-ID: GB - __ __ __ - __ __ __

Date:

EORTC QLQ - BR23

Patients sometimes report that they have the following symptoms or problems. Please indicate the extent to which you have experienced these symptoms or problems during the past week.

During the past week:		**Not at All**	**A Little**	**Quite a Bit**	**Very Much**
31.	Did you have a dry mouth?	1	2	3	4
32.	Did food and drink taste different than usual?	1	2	3	4
33.	Were your eyes painful, irritated or watery?	1	2	3	4
34.	Have you lost any hair?	1	2	3	4
35.	Answer this question only if you had any hair loss: Were you upset by the loss of your hair?	1	2	3	4
36.	Did you feel ill or unwell?	1	2	3	4
37.	Did you have hot flushes?	1	2	3	4
38.	Did you have headaches?	1	2	3	4
39.	Have you felt physically less attractive as a result of your disease or treatment?	1	2	3	4
40.	Have you been feeling less feminine as a result of your disease or treatment?	1	2	3	4
41.	Did you find it difficult to look at yourself naked?	1	2	3	4
42.	Have you been dissatisfied with your body?	1	2	3	4
43.	Were you worried about your health in the future?	1	2	3	4

During the past <u>four</u> weeks:		**Not at All**	**A Little**	**Quite a Bit**	**Very Much**
44.	To what extent were you interested in sex?	1	2	3	4
45.	To what extent were you sexually active? (with or without intercourse)	1	2	3	4
46.	Answer this question only if you have been sexually active: To what extent was sex enjoyable for you?	1	2	3	4

Please go on to the next page

During the past week:		**Not at All**	**A Little**	**Quite a Bit**	**Very Much**
47.	Did you have any pain in your arm or shoulder?	1	2	3	4
48.	Did you have a swollen arm or hand?	1	2	3	4
49.	Was it difficult to raise your arm or to move it sideways?	1	2	3	4
50.	Have you had any pain in the area of your affected breast?	1	2	3	4
51.	Was the area of your affected breast swollen?	1	2	3	4
52.	Was the area of your affected breast oversensitive?	1	2	3	4
53.	Have you had skin problems on or in the area of your affected breast (e.g., itchy, dry, flaky)?	1	2	3	4

FUNCTIONING, DISABILITY AND HEALTH QUESTIONNAIRE

AFTER BREASTCANCER TREATMENT - QUESTIONNAIRE LYMPH-ICF-UL

Patient ID: G B - __ __ __ - __ __ __

Date: _____

Symptoms from your arm after treatment for breast cancer can cause physical and mental complaints, as well as activity restrictions and problems participating in social life.
This questionnaire consists of **29 questions** and is constructed from information given by subjects suffering from this condition.

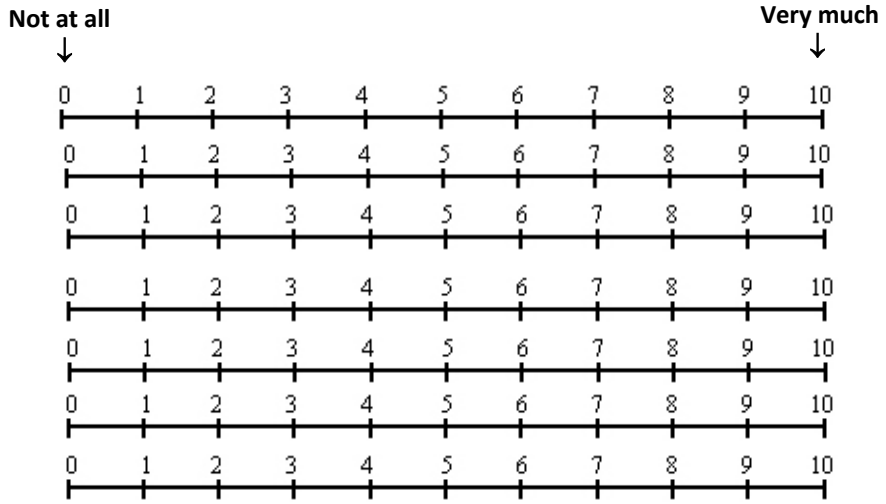
Next to each question the numbers 0 to 10 are given. The end of the scale corresponds with “Very good” and “Not at all”. Please indicate the number that fits the best. This indicates to which extent you experience problems related to your arm or to which extent you can perform activities of daily life. Select the empty circle to the right if the activity is not applicable.

Choose an answer according to your **complaints during the last 2 weeks**. Try not to think too long about answering a certain question. Please do not leave any questions unanswered.

This is a **personal questionnaire**, to be filled in by you alone. Do not discuss these items with others in your immediate surroundings.

Physical functions

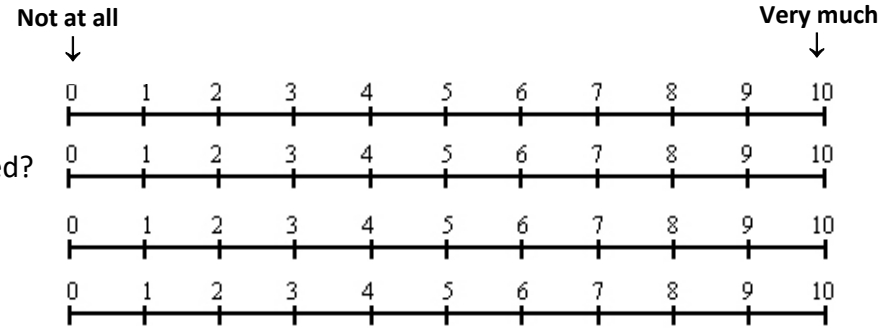
Does your arm:



1. Feel heavy?
2. Feel stiff?
3. Feel swollen?
4. Feel like it has lost strength?
5. Tingle?
6. Hurt?
7. Have a tensed skin?

Mental functions

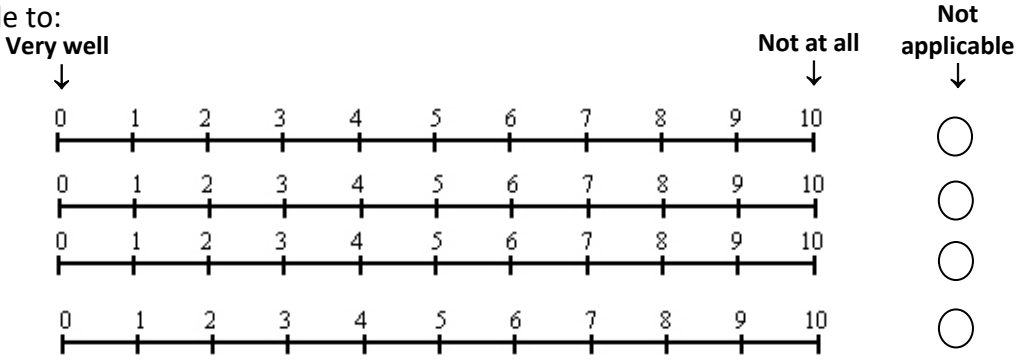
Due to your arm problems:



8. Do you feel sad?
9. Do you feel discouraged?
10. Do you have a lack of self-confidence?
11. Do you feel stressed?

Household activities

How well are you able to:

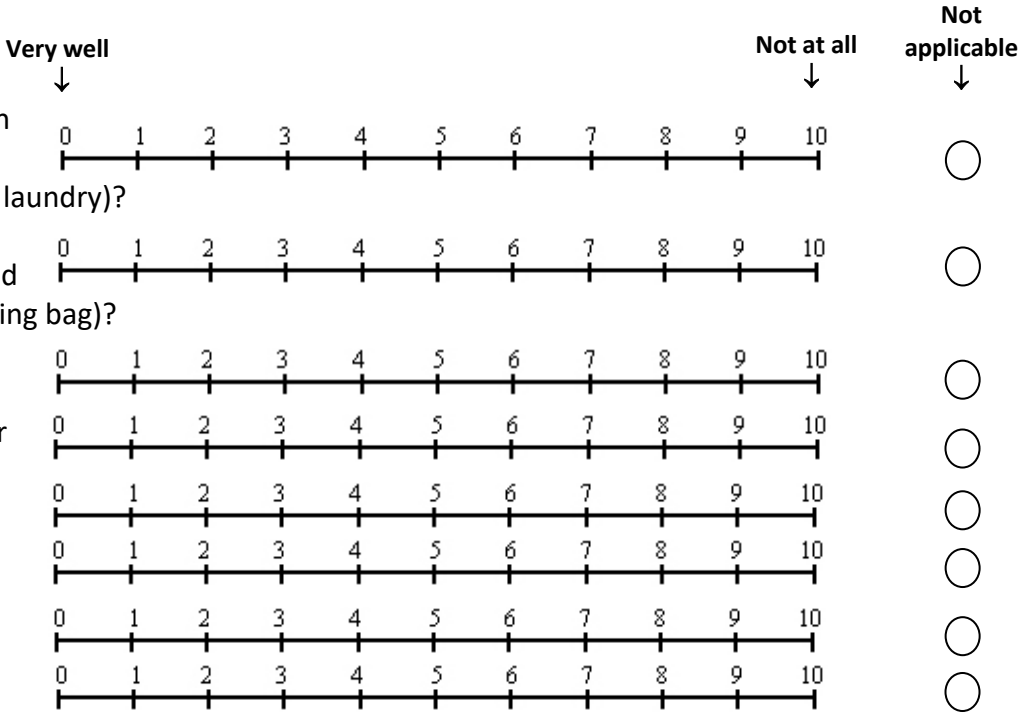


12. Clean (scrub, vacuum,mop)?
13. Cook?
14. Iron?
15. Work in the garden?

➔ **Page 2**

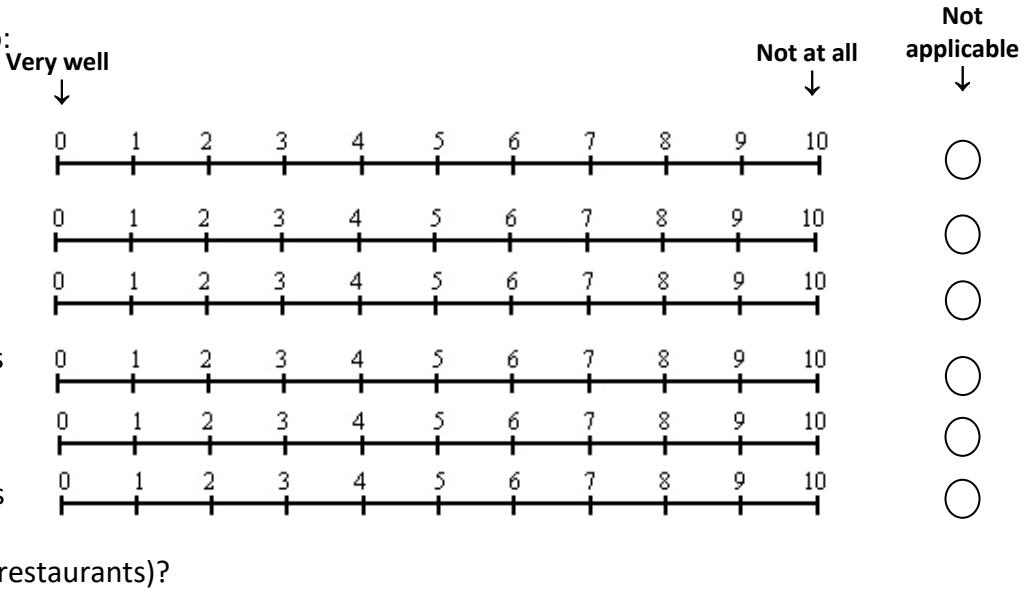
Mobility activitities

How well are you able to:



Life and social activities

How well are you able to:



Thank you for your participation!

AXSANA-Study Patient-ID: GB - __ __ __ - __ __ __

Date:

ORIENTATION TO LIFE QUESTIONNAIRE
(Antonovsky A. 1987)

Here is a series of questions relating to various aspects of our lives. Each question has seven possible answers. Please mark the number which expresses your answer, with numbers 1 to 7. If the words under 1 are right for you, circle 1; if the words under 7 are right for you, circle 7. If you feel differently, circle the number which best expresses you feeling. Please give only one answer to each question.

1. Do you have the feeling that you don't really care about what goes on around you?

1	2	3	4	5	6	7
very seldom or never						very often

2. Has it happened in the past that you were surprised by the behavior of people whom you thought you knew well?

1	2	3	4	5	6	7
never happened						always happened

3. Has it happened that people whom you counted on disappointed you?

1	2	3	4	5	6	7
never happened						always happened

4. Until now your life has had:

1	2	3	4	5	6	7
no clear goals or purpose at all						very clear goals and purpose

5. Do you have the feeling that you're being treated unfairly?

1	2	3	4	5	6	7
very often						very seldom or never

6. Do you have the feeling that you are in an unfamiliar situation and don't know what to do?

1	2	3	4	5	6	7
very often						very seldom or never

7. Doing the things you do every day is:

1	2	3	4	5	6	7
a source of deep pleasure and satisfaction						a source of pain and boredom

8. Do you have very mixed-up feelings and ideas?

1	2	3	4	5	6	7
very often						very seldom or never

9. Does it happen that you have feelings inside you would rather not feel?

1	2	3	4	5	6	7
very often						very seldom or never

10. Many people - even those with a strong character – sometimes feel like sad sacks (losers) in certain situations. How often have you felt this way in the past?

1	2	3	4	5	6	7
never						very often

11. When something happened, have you generally found that:

1	2	3	4	5	6	7
you overestimated or underestimated its importance						you saw things in the right proportion

12. How often do you have the feeling that there's little meaning in the things that you do in your daily life?

1	2	3	4	5	6	7
very often						very seldom or never

13. How often do you have feelings that you're not sure you can keep under control?

1	2	3	4	5	6	7
very often						very seldom or never

AXSANA study

Date: _____ Patient ID: G B - __ __ __ - __ __

This questionnaire is about your exercise activity and your smoking habits.

1. Considering the last month, how many days of the week have you performed at least one exercise activity (including walking and cycling) that lasted for at least 30 minutes?

- ☐ None
- ☐ Fewer than 1 day/week
- ☐ 1 day/week
- ☐ 2 days/week
- ☐ 3 days/week
- ☐ 4 days/week
- ☐ 5 days/week
- ☐ 6 days/week
- ☐ 7 days/week

2. How has your exercise activity today changed compared with the time before you were diagnosed with breast cancer?

- ☐ It has increased
- ☐ It has decreased
- ☐ It is unchanged

3. Do you smoke?

- ☐ Yes
- ☐ No, I have never smoked
- ☐ No, but I have smoked previously

Thank you for your participation!