Dear Mr/Mrs,

Your treatment at MAASTRO Clinic is about to start. We would like to know how much discomfort you experience as a result of the treatment at several points throughout the treatment period. We would therefore like to ask you to complete this short questionnaire. The questionnaire will be used as a supplement to your appointment with the doctor. After your treatment we will ask you to complete this questionnaire again approximately four times per year. You will receive the questionnaire in the post with a return envelope.

The questionnaire consists of different topics. A number of options will be listed per topic. Please read them carefully and choose the option that applies most to you at that time. We will also ask you to provide your most recent weight (taken at home or at the doctor's). You can return the completed questionnaire to us in the enclosed return envelope.

If you have any questions, please don’t hesitate to ask the doctor’s assistant or your doctor for more explanation.

We would like to thank you for your participation.

Yours sincerely,

Datacenter MAASTRO Clinic

Dear Mr/Mrs,

Please find enclosed the questionnaire regarding the treatment you received at MAASTRO Clinic.

The questionnaire contains eight questions about different topics, with several options per question. Please read them carefully and choose the option that best applies to you at this time. We will also ask you to provide your most recent weight (taken at home or at the doctor's). You can return the completed questionnaire to us in the enclosed return envelope.

We would like to thank you for your participation.

Yours sincerely,

Datacenter MAASTRO Clinic

Name:
Date of birth:
Patient number:

Date of completing the questionnaire: ___/___/_____
dd/mm/yyyy
Your current weight: _____,____ kg

1. Are you able to perform your daily activities?
   - 0 I am able to perform my daily activities as normal, without limitations.
   - 0 I am only limited in performing physically demanding tasks; there are a number of demanding tasks in the house or at work that I cannot perform.
   - 0 I am limited in my activities, but I am out of my bed or chair for more than half of the day.
   - 0 I am out of my bed or chair for less than half the day and I need care.
   - 0 I am completely in need of help, completely dependent on care, bedridden or limited to sitting.

2. Do you have difficulty swallowing?
   - 0 I have no difficulty swallowing.
   - 0 I have some difficulty swallowing, but I can eat normally.
   - 0 I have a lot of difficulty swallowing and I have had to adjust my eating habits accordingly. There are some foods that I cannot eat.
   - 0 I have a lot of difficulty swallowing, making it impossible for me to eat normally. I was admitted to the hospital as a result of this, or I am receiving food via a tube or drip.
   - 0 I was admitted to the hospital with life-threatening swallowing problems.

3. Have you lost weight <u>as a result of your illness or treatment</u>?
   - 0 I have not lost any significant weight as a result of my illness or treatment.
   - 0 I have lost less than 5 kg as a result of my illness or treatment.
   - 0 I have lost between 5 and 10 kg as a result of my illness or treatment and I am receiving a food supplement.
   - 0 I have lost more than 10 kg as a result of my illness or treatment and I am receiving food through a tube.

4. Are you experiencing pain?
   - 0 I am experiencing no pain.
   - 0 I am experiencing mild pain, but this does not limit my daily activities.
   - 0 I am experiencing moderate pain and I am taking pain relief, but I am not limited in my daily activities.
   - 0 I am experiencing severe pain and I am hardly capable of performing my daily activities.
   - 0 As a result of severe pain I am no longer capable of performing my daily activities.

5. Do you experience shortness of breath?

0 I do not experience any shortness of breath, not even when performing demanding activities, such as climbing stairs, going shopping, etc.
0 I experience shortness of breath, but I am still able to climb a flight of stairs or walk 100 meters without stopping.
0 I experience shortness of breath and as a result I am unable to climb a flight of stairs and cannot walk 100 meters without stopping.
0 I experience shortness of breath when performing light tasks such as washing myself, taking a shower, etc.
0 I experience shortness of breath even when at rest and I continuously need oxygen.

6. Do you have a cough?

0 I do not have a cough.
0 I have a mild cough, but I do not take any medication or prescription drugs for it; home remedies are sufficient.
0 I have a moderate cough and I am taking medicine or prescription drugs for it. This sometimes limits me in performing my daily activities, but I am fully capable of taking care of myself.
0 I have a persistent cough, which makes it difficult to care for myself (e.g. showering, getting dressed) and/or get enough sleep.

7. Do you cough up any phlegm?

0 I do not cough up any phlegm.
0 I sometimes cough up a little phlegm.
0 I cough up phlegm and this limits me in performing my daily activities.
0 I cough up so much phlegm that I have trouble taking care of myself.

8. Do you cough up any blood?

0 I do not cough up any blood.
0 I cough up some blood.
0 I suffer significant blood loss and I am receiving an operation or laser treatment for this.
0 I suffer severe blood loss and I will get a blood transfusion.
0 I have suffered very severe blood loss and I have had to have an operation for this.