

# headandneck 5000

## Questionnaire Pack – Baseline (Bristol)

**Thank you for agreeing to take part in this study.**

**This questionnaire pack contains several sets of questions that we would like you to complete.**

**Please take time to read the instructions for each set of questions, but do not waste too much time thinking about your responses, as there are no right or wrong answers.**

**If you have any questions whilst completing the questionnaire, do not hesitate to contact the study team (details below).**

**In the unlikely event that you may find some of the questions intrusive or upsetting, please contact the study team and we will respond to your concerns.**

**Thank you once again for taking the time to answer these questions.**

**We assure you that your responses will be kept confidential.**

**Professor Andy Ness  
The Head & Neck 5000 Study Team  
Room T106b Chapter House  
Bristol Dental School  
Lower Maudlin Street  
Bristol BS1 2LY  
Telephone: 0117 342 2519  
Email: headandneck5000@uhbristol.nhs.uk**

Study number: 

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## Questionnaire Pack – Baseline Bristol

**Version 4.2**  
**13/05/13**

### Your Outlook

*Instructions:*

Please answer the following questions about yourself by indicating the extent of your agreement using the following scale.

Be as honest as you can throughout, and try not to let your responses to one statement influence your response to other statements. There are no right or wrong answers. Answer according to your own feelings rather than how you think 'most people' would answer.

	<b>Strongly disagree</b>	<b>Disagree</b>	<b>Neutral</b>	<b>Agree</b>	<b>Strongly agree</b>
B1. In uncertain times, I usually expect the best.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
B2. It's easy for me to relax.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
B3. If something can go wrong for me, it will.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
B4. I'm always optimistic about my future.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
B5. I enjoy my friends a lot.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
B6. It's important for me to keep busy.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
B7. I hardly ever expect things to go my way.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
B8. I don't get upset too easily.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
B9. I rarely count on good things happening to me.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>
B10. Overall, I expect more good things to happen to me than bad.	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>	<input type="checkbox"/> <sub>5</sub>

### Your General Health

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

	<b>Not at all</b>	<b>A little</b>	<b>Quite a bit</b>	<b>Very much</b>
C1 Do you have any trouble doing strenuous activities, like carrying a heavy shopping bag or a suitcase?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
C2 Do you have any trouble taking a <u>long</u> walk?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

		Not at all	A little	Quite a bit	Very much
C3	Do you have any trouble taking a <u>short</u> walk outside of the house?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
C4	Do you need to stay in bed or a chair during the day?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
C5	Do you need help with eating, dressing, washing yourself or using the toilet?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
<b>During the past week:</b>		<b>Not at all</b>	<b>A little</b>	<b>Quite a bit</b>	<b>Very much</b>
C6	Were you limited in doing either your work or other daily activities?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
C7	Were you limited in pursuing your hobbies or other leisure time activities?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
C8	Were you short of breath?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
C9	Have you had pain?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
C10	Did you need to rest?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
C11	Have you had trouble sleeping?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
C12	Have you felt weak?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
C13	Have you lacked appetite?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
C14	Have you felt nauseated?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
C15	Have you vomited?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
C16	Have you been constipated?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
C17	Have you had diarrhoea?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
C18	Were you tired?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

<b>During the past week:</b>		<b>Not at all</b>	<b>A little</b>	<b>Quite a bit</b>	<b>Very much</b>
C19	Did pain interfere with your daily activities?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
C20	Have you had difficulty in concentrating on things, like reading a newspaper or watching television?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
C21	Did you feel tense?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
C22	Did you worry?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
C23	Did you feel irritable?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
C24	Did you feel depressed?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
C25	Have you had difficulty remembering things?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
C26	Has your physical condition or medical treatment interfered with your <u>family</u> life?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
C27	Has your physical condition or medical treatment interfered with your <u>social</u> activities?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
C28	Has your physical condition or medical treatment caused you financial difficulties?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

**For the following questions please tick the box between 1 and 7 that best applies to you**

C29 How would you rate your overall health during the past week?

Very poor    <sub>1</sub>    <sub>2</sub>    <sub>3</sub>    <sub>4</sub>    <sub>5</sub>    <sub>6</sub>    <sub>7</sub>    Excellent

C30 How would you rate your overall quality of life during the past week?

Very poor    <sub>1</sub>    <sub>2</sub>    <sub>3</sub>    <sub>4</sub>    <sub>5</sub>    <sub>6</sub>    <sub>7</sub>    Excellent

### Specific Aspects of Your Health

*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. Please answer all of the questions yourself by ticking the box that best applies to you. There are no "right" or "wrong" answers.*

<b>During the past week:</b>	<b>Not at all</b>	<b>A little</b>	<b>Quite a bit</b>	<b>Very much</b>
D1 Have you had pain in your mouth?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
D2 Have you had pain in your jaw?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
D3 Have you had soreness in your mouth?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
D4 Have you had a painful throat?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
D5 Have you had problems swallowing liquids?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
D6 Have you had problems swallowing pureed food?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
D7 Have you had problems swallowing solid food?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
D8 Have you choked when swallowing?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
D9 Have you had problems with your teeth?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
D10 Have you had problems opening your mouth wide?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
D11 Have you had a dry mouth?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
D12 Have you had sticky saliva?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
D13 Have you had problems with your sense of smell?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
D14 Have you had problems with your sense of taste?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

During the past week:		Not at all	A little	Quite a bit	Very much
D15	Have you coughed?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
D16	Have you been hoarse?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
D17	Have you felt ill?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
D18	Has your appearance bothered you?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
D19	Have you had trouble eating?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
D20	Have you had trouble eating in front of your family?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
D21	Have you had trouble eating in front of other people?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
D22	Have you had trouble enjoying your meals?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
D23	Have you had trouble talking to other people?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
D24	Have you had trouble talking on the telephone?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
D25	Have you had trouble having social contact with your family?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
D26	Have you had trouble having social contact with friends?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
D27	Have you had trouble going out in public?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
D28	Have you had trouble having physical contact with family or friends?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
D29	Have you felt less interest in sex?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
D30	Have you felt less sexual enjoyment?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

**During the past week:****Yes****No**D31 Have you used pain-killers? <sub>1</sub> <sub>2</sub>D32 Have you taken any nutritional supplements (excluding vitamins)? <sub>1</sub> <sub>2</sub>D33 Have you used a feeding tube? <sub>1</sub> <sub>2</sub>D34 Have you lost weight? <sub>1</sub> <sub>2</sub>D35 Have you gained weight? <sub>1</sub> <sub>2</sub>**Your Feelings**

*Please choose one response from the four given for each question. Please give your immediate response and don't think too long about your answer.*

**E1 I feel tense or 'wound up':**

- <sub>1</sub> Most of the time  
<sub>2</sub> A lot of the time  
<sub>3</sub> From time to time, occasionally  
<sub>4</sub> Not at all

**E2 I still enjoy the things I used to enjoy:**

- <sub>1</sub> Definitely as much  
<sub>2</sub> Not quite so much  
<sub>3</sub> Only a little  
<sub>4</sub> Hardly at all

**E3 I get a sort of frightened feeling as if something awful is about to happen:**

- <sub>1</sub> Very definitely and quite badly  
<sub>2</sub> Yes, but not too badly  
<sub>3</sub> A little, but it doesn't worry me  
<sub>4</sub> Not at all

**E4 I can laugh and see the funny side of things:**

- <sub>1</sub> As much as I always could  
<sub>2</sub> Not quite so much now  
<sub>3</sub> Definitely not so much now  
<sub>4</sub> Not at all



**E5 Worrying thoughts go through my mind:**

- <sub>1</sub> A great deal of the time
- <sub>2</sub> A lot of the time
- <sub>3</sub> From time to time, but not too often
- <sub>4</sub> Only occasionally

**E6 I feel cheerful:**

- <sub>1</sub> Not at all
- <sub>2</sub> Not often
- <sub>3</sub> Sometimes
- <sub>4</sub> Most of the time

**E7 I can sit at ease and feel relaxed:**

- <sub>1</sub> Definitely
- <sub>2</sub> Usually
- <sub>3</sub> Not often
- <sub>4</sub> Not at all

**E8 I feel as if I am slowed down:**

- <sub>1</sub> Nearly all the time
- <sub>2</sub> Very often
- <sub>3</sub> Sometimes
- <sub>4</sub> Not at all

**E9 I get a sort of frightened feeling like 'butterflies' in the stomach:**

- <sub>1</sub> Not at all
- <sub>2</sub> Occasionally
- <sub>3</sub> Quite often
- <sub>4</sub> Very often

**E10 I have lost interest in my appearance:**

- <sub>1</sub> Definitely
- <sub>2</sub> I don't take as much care as I should
- <sub>3</sub> I may not take quite as much care
- <sub>4</sub> I take just as much care as ever

**E11 I feel restless as I have to be on the move:**

- <sub>1</sub> Very much indeed  
<sub>2</sub> Quite a lot  
<sub>3</sub> Not very much  
<sub>4</sub> Not at all

**E12 I look forward with enjoyment to things:**

- <sub>1</sub> As much as I ever did  
<sub>2</sub> Rather less than I used to  
<sub>3</sub> Definitely less than I used to  
<sub>4</sub> Hardly at all

**E13 I get sudden feelings of panic:**

- <sub>1</sub> Very often indeed  
<sub>2</sub> Quite often  
<sub>3</sub> Not very often  
<sub>4</sub> Not at all

**E14 I can enjoy a good book or radio or TV program:**

- <sub>1</sub> Often  
<sub>2</sub> Sometimes  
<sub>3</sub> Not often  
<sub>4</sub> Very seldom

## Your Diet

*We would now like to ask you a few questions about your diet over the past year.*

**F1 In summary, how many servings of fruit do you usually eat, not counting juices?**

- <sub>1</sub> None  
<sub>2</sub> Less than one per month  
<sub>3</sub> 1 – 3 per month  
<sub>4</sub> 1 per week  
<sub>5</sub> 2 – 4 per week  
<sub>6</sub> 5 – 6 per week  
<sub>7</sub> 1 per day  
<sub>8</sub> 2 – 3 per day  
<sub>9</sub> 4 – 5 per day  
<sub>10</sub> 6 or more per day

**F2 In summary, how many servings of vegetables do you usually eat, not counting salad or potatoes?**

- <sub>1</sub> None
- <sub>2</sub> Less than one per month
- <sub>3</sub> 1 – 3 per month
- <sub>4</sub> 1 per week
- <sub>5</sub> 2 – 4 per week
- <sub>6</sub> 5 – 6 per week
- <sub>7</sub> 1 per day
- <sub>8</sub> 2 – 3 per day
- <sub>9</sub> 4 – 5 per day
- <sub>10</sub> 6 or more per day

**F3 In summary, how often do you eat deep fried food (e.g. French fries, fried chicken, fried fish, fried clams, fried shrimp etc.)?**

- <sub>1</sub> Never
- <sub>2</sub> Less than once per week
- <sub>3</sub> Once per week
- <sub>4</sub> 2 – 4 times per week
- <sub>5</sub> 5 – 6 times per week
- <sub>6</sub> Daily

### Your Quality of Life

*This questionnaire asks about your views about your health and quality of life **during the past seven days**. Please answer the following questions and statements as indicated.*

**I1. Pain (Tick one box:  )**

- <sub>1</sub> I have no pain.
- <sub>2</sub> There is mild pain not needing medication.
- <sub>3</sub> I have moderate pain - requires regular medication (e.g. paracetamol).
- <sub>4</sub> I have severe pain controlled only by prescription medicine (e.g. morphine).
- <sub>5</sub> I have severe pain, not controlled by medication.

**12. Appearance (Tick one box:  )**

- 1 There is no change in my appearance.
- 2 The change in my appearance is minor.
- 3 My appearance bothers me but I remain active.
- 4 I feel significantly disfigured and limit my activities due to my appearance.
- 5 I cannot be with people due to my appearance.

**13. Activity (Tick one box:  )**

- 1 I am as active as I have ever been.
- 2 There are times when I can't keep up my old pace, but not often.
- 3 I am often tired and have slowed down my activities, although I still get out.
- 4 I don't go out, because I don't have the strength.
- 5 I am usually in bed or chair and don't leave home.

**14. Recreation (Tick one box:  )**

- 1 There are no limitations to recreation at home or away from home.
- 2 There are a few things I can't do, but I still get out and enjoy life.
- 3 There are many times when I wish I could get out more, but I'm not up to it.
- 4 There are severe limitations to what I can do, mostly I stay at home and watch TV.
- 5 I can't do anything enjoyable.

**15. Swallowing (Tick one box:  )**

- 1 I can swallow as well as ever.
- 2 I cannot swallow certain solid foods.
- 3 I can only swallow liquid food.
- 4 I cannot swallow because it "goes down the wrong way" and chokes me.

**16. Chewing (Tick one box:  )**

- 1 I can chew as well as ever.
- 2 I can eat soft solids but cannot chew some foods.
- 3 I cannot even chew soft solids.

**17. Speech (Tick one box:  )**

- 1 My speech is the same as always.
- 2 I have difficulty with saying some words, but I can be understood over the phone.
- 3 Only my family and friends can understand me.
- 4 I cannot be understood.

**18. Shoulder (Tick one box:  )**

- 1 I have no problem with my shoulder.
- 2 My shoulder is stiff but it has not affected my activity or strength.
- 3 Pain or weakness in my shoulder has caused me to change my work / hobbies.
- 4 I cannot work or do my hobbies due to problems with my shoulder.

**I9. Taste (Tick one box:  )**

- <sub>1</sub> I can taste food normally.
- <sub>2</sub> I can taste most foods normally.
- <sub>3</sub> I can taste some foods.
- <sub>4</sub> I cannot taste any foods.

**I10. Saliva (Tick one box:  )**

- <sub>1</sub> My saliva is of normal consistency.
- <sub>2</sub> I have less saliva than normal, but it is enough.
- <sub>3</sub> I have too little saliva.
- <sub>4</sub> I have no saliva.

**I11. Mood (Tick one box:  )**

- <sub>1</sub> My mood is excellent and unaffected by my cancer.
- <sub>2</sub> My mood is generally good and only occasionally affected by my cancer.
- <sub>3</sub> I am neither in a good mood nor depressed about my cancer.
- <sub>4</sub> I am somewhat depressed about my cancer.
- <sub>5</sub> I am extremely depressed about my cancer.

**I12. Anxiety (Tick one box:  )**

- <sub>1</sub> I am not anxious about my cancer.
- <sub>2</sub> I am a little anxious about my cancer.
- <sub>3</sub> I am anxious about my cancer.
- <sub>4</sub> I am very anxious about my cancer.

**I13. Which issues have been the most important to you during the past 7 days?**

Tick  up to 3 boxes.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> <sub>1</sub> Pain       | <input type="checkbox"/> <sub>5</sub> Swallowing | <input type="checkbox"/> <sub>9</sub> Taste    |
| <input type="checkbox"/> <sub>2</sub> Appearance | <input type="checkbox"/> <sub>6</sub> Chewing    | <input type="checkbox"/> <sub>10</sub> Saliva  |
| <input type="checkbox"/> <sub>3</sub> Activity   | <input type="checkbox"/> <sub>7</sub> Speech     | <input type="checkbox"/> <sub>11</sub> Mood    |
| <input type="checkbox"/> <sub>4</sub> Recreation | <input type="checkbox"/> <sub>8</sub> Shoulder   | <input type="checkbox"/> <sub>12</sub> Anxiety |

**GENERAL QUESTIONS**

**I14. Compared to the month before you developed cancer, how would you rate your health- related quality of life? (Tick one box:  )**

- <sub>1</sub> Much better
- <sub>2</sub> Somewhat better
- <sub>3</sub> About the same
- <sub>4</sub> Somewhat worse
- <sub>5</sub> Much worse

**I15. In general, would you say your *health-related quality of life* during the past 7 days has been:**

**(Tick one box:  )**

- <sub>1</sub> Outstanding
- <sub>2</sub> Very good
- <sub>3</sub> Good
- <sub>4</sub> Fair
- <sub>5</sub> Poor
- <sub>6</sub> Very poor

**I16. Overall quality of life includes not only physical and mental health, but also many other factors, such as family, friends, spirituality, or personal leisure activities that are important to your enjoyment of life. Considering everything in your life that contributes to your personal well-being, rate your *overall quality of life* during the past 7 days. (Tick one box:  )**

- <sub>1</sub> Outstanding
- <sub>2</sub> Very good
- <sub>3</sub> Good
- <sub>4</sub> Fair
- <sub>5</sub> Poor
- <sub>6</sub> Very poor

**I17A. Please indicate on the following lines any items (medical or non-medical) that are important to your quality of life and have not been adequately addressed in the above questions and statements.**

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**Difficulties in Your Life**

*Please read each question carefully and tick the response that best describes your answer.*

- Please answer each question as honestly as possible.
- If you are not completely sure which response is the most accurate tick the box that you feel is the most appropriate.
- Please tick the 'no difficulty box' if a question does not apply to you.
- Do not spend long on each statement.

<b>During the past month:</b>	<b>No difficulty</b>	<b>A little</b>	<b>Quite a bit</b>	<b>Very much</b>
J1 Have you had any difficulty maintaining your independence?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

<b>During the past month:</b>		<b>No difficulty</b>	<b>A little</b>	<b>Quite a bit</b>	<b>Very much</b>
J2	Have you had any difficulty in carrying out your domestic chores? (e.g. cleaning, gardening, cooking, shopping)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
J3	Have you had any difficulty with managing your own personal care? (e.g. bathing, dressing, washing)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
J4	Have you had any difficulty with looking after those who depend on you? (e.g. children, dependent adults, pets)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
J5	Have any of those close to you (e.g. partner, children, parents) had any difficulty with the support available to them?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
J6	Have you had any difficulties with benefits? (e.g. statutory sick pay, attendance allowance, disability living allowance)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
J7	Have you had any financial difficulties?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
J8	Have you had any difficulties with financial services? (e.g. loans, mortgages, pensions, insurance)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
J9	Have you had any difficulty concerning your work? (or education if you are a student)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
J10	Have you had any difficulty with planning for your own or your family's future? (e.g. care of dependents, legal issues, business affairs)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
J11	Have you had any difficulty with communicating with those closest to you? (e.g. partner, children, parents)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
J12	Have you had any difficulty communicating with others? (e.g. friends, neighbours, colleagues, dates)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
J13	Have you had any difficulty concerning sexual matters?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
J14	Have you had any difficulty concerning plans to have a family?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
J15	Have you had any difficulty concerning your appearance or body image?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

During the past month:		No difficulty	A little	Quite a bit	Very much
J16	Have you felt isolated?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
J17	Have you had any difficulty with getting around? (e.g. transport, car parking, your mobility)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
J18	Have you had any difficulty with where you live? (e.g. space, access, damp, heating, neighbours, security)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
J19	Have you had any difficulty in carrying out your recreational activities? (e.g. hobbies, pastimes, social pursuits)	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
J20	Have you had any difficulty with your plans to travel or take a holiday?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>
J21	Have you had any difficulty with any other area of your everyday life?	<input type="checkbox"/> <sub>1</sub>	<input type="checkbox"/> <sub>2</sub>	<input type="checkbox"/> <sub>3</sub>	<input type="checkbox"/> <sub>4</sub>

### Your Appearance

**K1A** Is there any aspect of the appearance of your head/neck (however small) that concerns you at all? **Yes** <sub>1</sub> **No** <sub>2</sub>

**If No**, please go to section K1B

**If Yes**, please continue:

**K2A** The aspect of my head/neck about which I am most sensitive or self-conscious is

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**K3A** The thing I don't like about the appearance of my head/neck is

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**K4A** If you are sensitive or concerned about any other features of your body or your appearance, please say what they are

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**Instructions:** The following questions are concerned with the way you feel or act. They are all simple. Please tick the answer that applies to you. If the item does not apply to you at all, tick the N/A (not applicable option). Don't spend long on any one question.

**K1B How confident do you feel?**

- Not at all <sub>1</sub>  
Slightly <sub>2</sub>  
Moderately <sub>3</sub>  
Extremely <sub>4</sub>

**K2B How distressed do you get when you see yourself in the mirror/window?**

- Extremely <sub>1</sub>  
Moderately <sub>2</sub>  
A little <sub>3</sub>  
Not at all distressed <sub>4</sub>

**K3B My self-consciousness makes me irritable at home:**

- N/A <sub>1</sub>  
Never/almost never <sub>2</sub>  
Sometimes <sub>3</sub>  
Often <sub>4</sub>  
Almost always <sub>5</sub>

**K4B How hurt do you feel?**

- Extremely <sub>1</sub>  
Moderately <sub>2</sub>  
Slightly <sub>3</sub>  
Not at all <sub>4</sub>

**K5B At present my self-consciousness has an adverse effect on my work:**

- Almost always <sub>1</sub>  
Often <sub>2</sub>  
Sometimes <sub>3</sub>  
Never/almost never <sub>4</sub>  
N/A <sub>5</sub>

**K6B How distressed do you get when you go to the beach?**

- N/A  <sub>1</sub>
- Not at all  <sub>2</sub>
- A little  <sub>3</sub>
- Moderately  <sub>4</sub>
- Extremely  <sub>5</sub>

**K7B Other people mis-judge me because of the appearance of my head/neck:**

- Almost always  <sub>1</sub>
- Often  <sub>2</sub>
- Sometimes  <sub>3</sub>
- Never/almost never  <sub>4</sub>
- N/A  <sub>5</sub>

**K8B How feminine/masculine do you feel?**

- Not at all  <sub>1</sub>
- Slightly  <sub>2</sub>
- Moderately  <sub>3</sub>
- Extremely  <sub>4</sub>

**K19B How distressed do you get when going to social events?**

- N/A  <sub>1</sub>
- Not at all  <sub>2</sub>
- Moderately  <sub>3</sub>
- A fair amount  <sub>4</sub>
- Extremely  <sub>5</sub>

**K20B How normal do you feel?**

- Not at all  <sub>1</sub>
- Slightly  <sub>2</sub>
- Moderately  <sub>3</sub>
- Extremely  <sub>4</sub>

**K21B At present my self-consciousness has an adverse effect on my sex life:**

- Almost always <sub>1</sub>
- Often <sub>2</sub>
- Sometimes <sub>3</sub>
- Never/almost never <sub>4</sub>
- N/A <sub>5</sub>

**K22B I avoid going out of the house:**

- Almost always <sub>1</sub>
- Often <sub>2</sub>
- Sometimes <sub>3</sub>
- Never/almost never <sub>4</sub>

**K23B How distressed do you get when other people make remarks about the appearance of your head/neck?**

- N/A <sub>1</sub>
- Not at all <sub>2</sub>
- Moderately <sub>3</sub>
- A fair amount <sub>4</sub>
- Extremely <sub>5</sub>

**K24B I avoid going to pubs/restaurants:**

- Almost always <sub>1</sub>
- Often <sub>2</sub>
- Sometimes <sub>3</sub>
- Never/almost never <sub>4</sub>
- N/A <sub>5</sub>

**K1C My feature causes me physical pain/discomfort:**

- Never/almost never <sub>1</sub>
- Sometimes <sub>2</sub>
- Often <sub>3</sub>
- Almost always <sub>4</sub>

**K2C My feature limits my physical ability to do the things I want to do:**

- Almost always <sub>1</sub>  
 Often <sub>2</sub>  
 Sometimes <sub>3</sub>  
 Never/almost never <sub>4</sub>

**K3C To what extent is any disfigurement or change to your appearance as a result of your cancer or its treatment noticeable to other people?**

- |                                       |                                       |                                       |                                       |                                       |                                       |                                       |  |                         |
|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|--|-------------------------|
| Not at all<br>noticeable              |                                       |                                       |                                       | Moderately<br>noticeable              |                                       |                                       |  | Extremely<br>noticeable |
| 1                                     | 2                                     | 3                                     | 4                                     | 5                                     | 6                                     | 7                                     |  |                         |
| <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> | <input type="checkbox"/> <sub>4</sub> | <input type="checkbox"/> <sub>5</sub> | <input type="checkbox"/> <sub>6</sub> | <input type="checkbox"/> <sub>7</sub> |  |                         |

**K4C How much will your treatment change the way you look?**

- |                                       |                                       |                                       |                                       |                                       |           |
|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|-----------|
| Not at all                            |                                       |                                       |                                       |                                       | Very much |
| 1                                     | 2                                     | 3                                     | 4                                     | 5                                     |           |
| <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> | <input type="checkbox"/> <sub>4</sub> | <input type="checkbox"/> <sub>5</sub> |           |

**K6C How much does this bother you?**

- |                                       |                                       |                                       |                                       |                                       |
|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|---------------------------------------|
| Not at all                            |                                       |                                       |                                       | Very much so                          |
| 1                                     | 2                                     | 3                                     | 4                                     | 5                                     |
| <input type="checkbox"/> <sub>1</sub> | <input type="checkbox"/> <sub>2</sub> | <input type="checkbox"/> <sub>3</sub> | <input type="checkbox"/> <sub>4</sub> | <input type="checkbox"/> <sub>5</sub> |

Thank you for  
completing the questionnaire