DRAFT

SWOG
S1200 FACT - ES TRIAL OUTCOME INDEX (VERSION 4)

SWOG Patient ID ☐☐☐☐☐☐ **SWOG Study No.** S 1 2 0 0 **Registration Step** 1

Patient Initials _____ (L, F M) **Date Form Completed:** ☐☐ / ☐☐ / ☐☐☐☐

Planned Assessment: ☐ Baseline ☐ 6-week visit ☐ 12-week visit ☐ 24-week visit ☐ 52-week visit

Institution / Affiliate _____ Physician _____

Instructions: You will be asked to complete this form at time of registration and at 6 weeks, 12 weeks, 24 weeks, and 52 weeks post-registration. All dates are **MONTH, DAY, YEAR**. Thank you for your participation on this study.

Below is a list of statements that other people with your illness have said are important.

By selecting one (1) box per line, please indicate how true each statement has been for you during the past 7 days. Please select a box by marking an X in it.

PHYSICAL WELL-BEING	**Not at all**	**A little bit**	**Some-what**	**Quite a bit**	**Very much**
1. I have a lack of energy	☐	☐	☐	☐	☐
2. I have nausea	☐	☐	☐	☐	☐
3. Because of my physical condition, I have trouble meeting the needs of my family	☐	☐	☐	☐	☐
4. I have pain	☐	☐	☐	☐	☐
5. I am bothered by side effects of treatment	☐	☐	☐	☐	☐
6. I feel ill	☐	☐	☐	☐	☐
7. I am forced to spend time in bed	☐	☐	☐	☐	☐

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By selecting one (1) box per line, please indicate how true each statement has been for you during the past 7 days. Please select a box by marking an X in it.

FUNCTIONAL WELL-BEING	**Not at all**	**A little bit**	**Some-what**	**Quite a bit**	**Very much**
1. I am able to work (include work at home)	☐	☐	☐	☐	☐
2. My work (include work at home) is fulfilling	☐	☐	☐	☐	☐
3. I am able to enjoy life	☐	☐	☐	☐	☐
4. I have accepted my illness	☐	☐	☐	☐	☐
5. I am sleeping well	☐	☐	☐	☐	☐
6. I am enjoying the things I usually do for fun	☐	☐	☐	☐	☐
7. I am content with the quality of my life right now	☐	☐	☐	☐	☐

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Planned Assessment: ☐ Baseline ☐ 6-week visit ☐ 12-week visit ☐ 24-week visit ☐ 52-week visit

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By selecting one (1) box per line, please indicate how true each statement has been for you during the past 7 days. Please select a box by marking an X in it.

ADDITIONAL CONCERNS	Not at all	A little bit	Some-what	Quite a bit	Very much
1. I have hot flashes	☐	☐	☐	☐	☐
2. I have cold sweats	☐	☐	☐	☐	☐
3. I have night sweats	☐	☐	☐	☐	☐
4. I have vaginal discharge	☐	☐	☐	☐	☐
5. I have vaginal itching/irritation	☐	☐	☐	☐	☐
6. I have vaginal bleeding or spotting	☐	☐	☐	☐	☐
7. I have vaginal dryness	☐	☐	☐	☐	☐
8. I have pain or discomfort with intercourse	☐	☐	☐	☐	☐
9. I have lost interest in sex	☐	☐	☐	☐	☐
10. I have gained weight	☐	☐	☐	☐	☐
11. I feel lightheaded (dizzy)	☐	☐	☐	☐	☐
12. I have been vomiting	☐	☐	☐	☐	☐
13. I have diarrhea	☐	☐	☐	☐	☐
14. I get headaches	☐	☐	☐	☐	☐
15. I feel bloated	☐	☐	☐	☐	☐
16. I have breast sensitivity/tenderness	☐	☐	☐	☐	☐
17. I have mood swings	☐	☐	☐	☐	☐
18. I am irritable	☐	☐	☐	☐	☐

Thank you for completing this questionnaire.

Cella DF, Tulsky DS, Gray G, et al. The Functional Assessment of Cancer Therapy scale: development and validation of the general measure. J Clin Oncol 1993;11:570-579/Fallowfield LJ, Leaity SK, Howell A, et al. Assessment of quality of life in women undergoing hormonal therapy for breast cancer: validation of an endocrine symptom subscale for the FACT-B. Breast Cancer Treat Res 1999;55:189-199.