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**HUNT 3**  
**Questionnaire 3**  
**Prostate cancer**

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**Dear HUNT participant,**

Thank you for participating in the first part of this health study. You have received this questionnaire because you answered Yes to the question about having or having had prostate cancer. We hope that you will also answer this questionnaire. Please put an X in the box of your answer for each question using a blue or black ball point pen or marker.

CORRECT  INCORRECT

Return the questionnaire in the enclosed, stamped envelope.

Date of completion

___/___200___
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**Put an X in the box to show to what extent you have had these symptoms or problems**

**THINK ABOUT THE PAST WEEK**

	Not at all	A little	Quite a bit	Very much
1. Was it difficult for you to get enough sleep, because you needed to get up frequently at night to urinate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you had difficulty going out of the house because you needed to be close to a toilet?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Did you have pain when you urinated?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Answer this question only if you wear an incontinence aid. Has wearing an incontinence aid been a problem for you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have your daily activities been limited by your urinary problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any unintentional release (leakage) of stools?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you had blood in your stools?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Have your daily activities been limited by your bowel problems?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Did you have hot flushes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have you had sore or enlarged nipples or breasts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have you had swelling in your legs or ankles?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Has weight loss been a problem for you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Has weight gain been a problem for you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**THINK ABOUT THE PAST 4 WEEKS**

	Not at all	A little	Quite a bit	Very much
14. To what extent were you interested in sex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. To what extent were you sexually active?(with or without intercourse)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. If you have been sexually active in the past four weeks, to what extent was sex enjoyable for you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Did you have difficulty getting or maintaining an erection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Did you have problems with ejaculation (e.g., so-called "dry ejaculation")?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Have you felt uncomfortable about being sexually intimate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Have you felt less masculine as a result of your disease or treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



**LIFE OUTLOOK**

Put an X in the box of the answer that best represents your view

	Strongly disagree	Disagree	Neutral	Agree	Strongly agree
24. Having had cancer makes me feel unsure about my future.	<input type="checkbox"/>				
25. I worry about my future.	<input type="checkbox"/>				
26. I am afraid to die.	<input type="checkbox"/>				
27. I feel like time in my life is running out.	<input type="checkbox"/>				
28. I learned something about life because of having had cancer.	<input type="checkbox"/>				
29. Having had cancer has made me realize that time is precious.	<input type="checkbox"/>				
30. Having had cancer has strengthened my religious faith or my sense of spirituality.	<input type="checkbox"/>				

*Return the questionnaire in the enclosed, stamped envelope.*

***Thank you for your participation in HUNT 3.***

